Universidade NOVA de Lisboa
Faculdade de Ciências Médicas

New University of Lisbon
Faculty of Medical Sciences

The effectiveness of training targeting stigma and improving attitudes of mental health professionals towards people with severe mental illness in Azerbaijan

By
Rustam Salayev, MD

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Supervisor: Professor José Miguel Caldas de Almeida, MD, PhD

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Summary

People suffering from mental disorders throughout the history were the subject of abuse, humiliation and mockery. They were more likely than other groups discriminated against and stigmatized by society.

The level of stigma, also the degree and form of combating it, varies depending on the country and its healthcare system. Mental health system means a process of mental illness prevention, treatment and rehabilitation of people with mental disorders, solving social and legal issues, etc. Mental health specialists play a significant role in the realization of these tasks. However, despite the fact that mental health specialists are called upon to help these people, very frequently they seem to be the carriers of a stigmatizing attitudes and behaviors.

This research was aimed to evaluate the degree of stigma in psychiatric in-patient nurses towards people with mental disorders, clarification of the possible interrelations between stigma and socio-demographic variables, as well as evaluation of the effectiveness of training in terms of reducing the level of stigma and increasing the level of knowledge in the nursing staff.

It was a cross-sectional study conducted on a convenient sample. The study involved 73 nurses working at three psychiatric hospitals. The socio-demographic questionnaire, SCAPS, CAMI and SDS scales were used as the assessment tools.

The results of this study can be used to prepare recommendations on improving mental health services in our country through reducing stigma towards mental health service users.

Sumário

As pessoas que sofrem de transtornos mentais têm sido, ao longo da história, alvo de abusos, humilhações e escárnio. Têm sido também mais propensos do que outros grupos a ser discriminados e estigmatizados pela sociedade.

O nível de estigma e a forma de o combater varia de país para país e conforme o sistema de saúde existente. Os sistemas de saúde mental incluem um processo de prevenção de doenças mentais, tratamento e reabilitação de pessoas com perturbações mentais, resolução de questões sociais e legais, etc. Os especialistas em saúde mental desempenham um papel significativo na realização destas tarefas. No entanto, apesar de estes especialistas em saúde mental serem chamados a ajudar essas pessoas, eles assumam com muita frequência atitudes e comportamentos estigmatizantes.

Este estudo teve como objetivo avaliar o grau de estigma observado em enfermeiros que trabalham em internamento psiquiátrico em relação a pessoas com perturbações mentais, esclarecer as possíveis inter-relações entre estigma e variáveis sociodemográficas, bem como avaliar a eficácia de programas de formação em termos de redução do nível estigma e aumento do nível de conhecimento na equipe de enfermagem.

Este foi um estudo transversal conduzido em numa amostra de conveniência. O estudo envolveu 73 enfermeiros que trabalhavam em três hospitais psiquiátricos. Como instrumentos de avaliação foram utilizados o questionário sociodemográfico e as escalas CAMI, SDS e SCAPS.

Os resultados deste estudo podem ser usados para preparar recomendações sobre a melhoria dos serviços de saúde mental no nosso país através da redução do estigma em relação aos utentes destes serviços.

Resúmen

Las personas que sufren trastornos mentales fueron, a lo largo de la historia, objeto de abuso, humillación y burla. Ellas fueron más propensas que otros grupos a ser discriminados y estigmatizados por la sociedad.

El nivel de estigma, así como también el grado y la forma de combatirlo, varía según el país y su sistema de salud. Los sistemas de salud mental significan un proceso de prevención de enfermedades mentales, tratamiento y rehabilitación de personas con trastornos mentales, solución de problemas sociales y legales, etc. Los especialistas en salud mental juegan un papel importante en la realización de estas tareas. Sin embargo, a pesar del hecho de que los especialistas en salud mental están llamados a ayudar a estas personas, con mucha frecuencia parecen ser portadores de actitudes y comportamientos estigmatizadores.

El objetivo de esta investigación fue evaluar el grado de estigma en enfermeras psiquiátricas que trabajan en servicios de internamiento con personas con trastornos mentales, aclarar las posibles interrelaciones entre el estigma y las variables sociodemográficas, así como evaluar la efectividad de programas de entrenamiento en términos de reducción del nivel de estigma y del aumento del nivel de conocimiento en el personal de enfermería.

Esto fue un estudio transversal realizado en una muestra de conveniencia. El estudio involucró a 73 enfermeras que trabajan en tres hospitales psiquiátricos. El cuestionario sociodemográfico y las escalas CAMI, SDS y SCAPS se utilizaron como herramientas de evaluación.

os resultados de este estudio pueden usarse para preparar recomendaciones sobre cómo mejorar los servicios de salud mental en nuestro país mediante la reducción del estigma hacia los usuarios de los servicios de salud mental.

Declaration

This thesis is submitted in partial fulfillment for the award of the International Masters in Mental Health Policy and Services at the Faculty of Medical Sciences, the University NOVA of Lisbon.

This thesis is a presentation of my original research work. Every effort is made to indicate clearly any involved contribution by others with due to literature references and acknowledgement of collaborative research and discussions.

The work has been presented partly or wholly neither to any other university or research institution nor elsewhere for publication.

_____ the 13 of March, 2018

Dr. Rustam Salayev

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List of Abbreviations

CAMI - Community Attitudes toward Mental Illness
CRPD - Convention on the Rights of Persons with Disabilities
MHAP - Mental Health Action Plan 2013 - 2020
MoH – Ministry of Health of the Republic of Azerbaijan
NAMI - National Alliance on Mental Illness
NMHC – National Mental Health Centre
NMHS – National Mental Health Strategy
NMHWFS – National Mental Health Workforce Strategy
OSCE - Organization for Security and Co-operation in Europe
RCT – Randomized controlled trials
SDS - Social Distance Scale
SKAPS - Schizophrenia Knowledge, Attitudes and Perceptions Scale
SMI – Severe Mental Illness
WHO – World Health Organization
WPA - World Psychiatric Association

Chapter 1. INTRODUCTION

1.1. Background

Azerbaijan is a country in the South Caucasus region of Eurasia at the crossroads of Eastern Europe and Western Asia. The country is a member state of the UN, the Council of Europe, the OSCE and the Eastern Partnership (EaP). From the total population of 9,810,000 people in 2017 nearly 53% were urban and 47% - the rural population. (Figure 1.1).

Figure 1.1 Azerbaijan Republic

Area - 86,6 thsd.sq.km
Population - 9810,0 thsd.person
(at the beginning of 2017)
Density of population for 1 sq.km - 113 person
Number of administrative territorial units:
Autonomous Republic - 1
Economical regions - 10
Regions - 66, Cities - 78
City districts - 14, Settlements - 261
Rural territorial division - 1727
Rural settlements - 4249
State borders:
in the south 765 km with Iran and 15 km with Turkey, in the north 390km with Russia, in the north-west 480 km with Georgia, in the west 1007 km with Armenia.

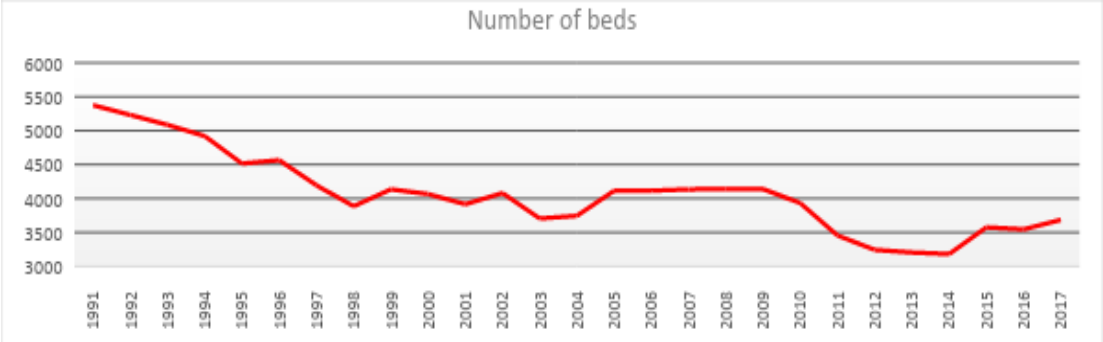
*Red spots indicate the cities in which the study was conducted

After a short period of independence in 1918-20 Azerbaijan had been occupied by Soviet Army and became a part of the Soviet Union until 1991.

After collapse of the Soviet Union and restoration of its independence Azerbaijan faced military conflict, a great number of refugees and internally displaced persons, and economic crisis, which caused social disaster affecting all areas including the health and mental health care. Over the first decade of independency mental health care system remained the main features of the old Soviet model characterized by institutional approach, over-centralization, segregation from general healthcare and other sectors, and limited number of services.

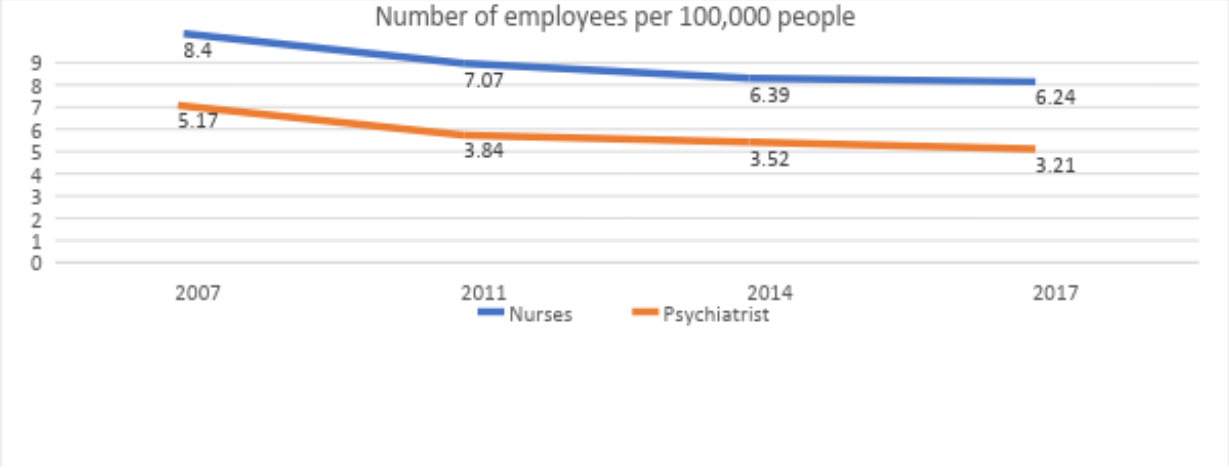
The situation began to change in the first decade of the 21st century. During this period, major steps were taken in reforming mental health care. For example, in 2001 the Law on psychiatric care was passed. In 2008, Azerbaijan signed the Convention on the Rights of Persons with Disabilities (CRPD). In 2011, the National Mental Health Policy and Strategic Action Plan were developed. According to the strategic plan, positive changes began to take place: the dispensaries were reformed, new services directed to improve the quality and accessibility of care to the population were opened and the process of deinstitutionalization was activated (Figure 1.2.).

Figure 1.2 The number of psychiatric beds in the country.



Despite certain achievements in the reforming process of mental health service many problems still exist. One of these problems is a shortage of human resources in mental health. The Figure 1.3. depicts significant reduction of psychiatrists and psychiatric nurses for the last decade. In fact mental health is not popular area for future career of young health professionals, while the main reason for that is stigma accompanying not only people with mental disorders but also mental health service providers.

Figure 1.3. The number of psychiatric nurses and psychiatrists in the country.



1.2. Workforce development

In 2013 National Mental Health Workforce Strategy (Ismailov et al., 2013) was developed. There are seven objectives of the strategy:

1. To improve workforce design and planning so as to root it in local services planning and make it understandable and meaningful to people in local services and other key organizations.
2. To identify and use creative means to recruit and retain people in the workforce in order to increase their capacity of mental health services in successive years.
3. To identify the new roles of traditional mental health service providers such as psychiatrists and psychiatric nurses as well as to develop new mental health professions to be integrated into mental health system
4. To facilitate new ways of working across professional boundaries in order to make the best use of specialist staff group to meet the needs of service users and carers.
5. To ensure participation of primary health care providers in mental health care provision
6. To empower service users and their families as well as representatives of public organizations, communities and volunteers as an important societal resource of workforce in mental health
7. To develop workforce through revised education, training and development at pre- and post-qualification levels and for continuing professional and practitioner development, increasingly focusing on the shared and distinct capabilities required to meet both staff and user needs.

The document describes standards of care, recruitment and retention of mental health staff, job assignments for newly introduced mental health professionals, including scopes of work, skills and required education.

In the line with this document, training programs have been developed in the country, new professions have been integrated in mental health, and the referral system has been improved.

At the same time, the main barrier of mental health reform is stigma preventing the shift from institutional services to modern community services. It is important to note that carriers of stigma include not only the representatives of general public, but also representatives of professional community, especially psychiatric nurses.

1.3. Rationale for this study

The struggle against stigma with respect to people with mental disorders has become the main component in a number of important programs and documents developed by respectable international organizations.

Since 1996, the World Psychiatric Association (WPA) has initiated the Global International Program to reduce stigma and discrimination because of schizophrenia (Sartorius & Schulze, 2005).

One of the most important documents calling for reducing stigma is the Convention on the Rights of Persons with Disabilities, based on the principles of respect for human worth and his/her freedom of choice, non-discrimination and principles of equality (United Nations, 2006).

Among the national arrangements aimed at improving the service in the field of mental health the National Mental Health Strategy plays an important role. One of the main objectives of this policy document is to protect the rights and interests of persons with mental disorders and counter stigma and discrimination (Ismailov F., Rasulov A., 2009). In addition, the Strategy considers development of human resource capacity through special short-term trainings.

Along with local programs, Azerbaijan also abides the documents developed by WHO. For example, Mental Health Action Plan 2013 - 2020, based on the principles of CRPD, focuses on eliminating discrimination and stigmatization towards people with mental disorders (World Health Organization, 2013).

This study will promote better understanding of stigma among in-patient nursing staff. Also the data obtained will give an opportunity to estimate to what extent anti-stigma training leads to changes in knowledge and attitudes in psychiatric nurses.

Based on the study results, it will be possible to formulate recommendations to improve services provided at in-patient facilities.

Chapter 2. LITERATURE REVIEW

2.1. Stigma towards people with mental disorders: review of studies.

The word stigma originates from ancient Greece and it means marking something or someone, for example, branding the slave's body (Brown & Bradley, 2002). One of the first authors who used the term stigma in Psychiatry was Goffman. In his book “Asylums: Essays on the Social Situation of Mental Patients and Other Inmates” (Goffman, 1961), based on personal practice and observations in a psychiatric hospital, he described the process of patients discrimination. In addition, Hoffmann is one of the founders of the "labeling theory" which depicts the mechanisms of interaction between the "*discretized*" and the "*discredited*", as well as the concept of *self-stigma* (Seeman & Goffman, 1964).

Modern researchers define stigma as a global process of negative, stereotypical attitude and discrimination by general public towards particular group of people and perception by this group of these actions (Bagley & King, 2005). In other words, stigma is a negative differentiation against some members of the society who are vulnerable due to specific state (Arboleda-Flórez & Sartorius, 2008).

People with mental disorders present a special group that is given humiliating (insane, loony, crazy, nuts, psycho, etc.) or emphasizing the presence of a particular disease (e.g. schizophrenic, epileptic, psychotic) nicknames (Gherman, Predescu, Iftene, & Achimaş Cadariu, 2008).

The negative consequences of stigma affect both the individual level and the level of society as a whole. Stigma causes such problems as difficulties in obtaining housing and job and, accordingly, increasing the level of homelessness and unemployment, can lead to criminalization of the society. The family breakdown and social isolation lead to economic losses, negatively affecting wellbeing and increasing the financial burden on the society. The lack of work and material resources prevent patients from receiving necessary services, which further increase their disability and marginalization (Overton & Medina, 2008).

Studies have shown that people exposed to stigmatization suffer more from stigma than from disease itself (Wilkinson, Piccinelli, Falloon, Krekorian, & McLees, 1995). As a result, stigma hinders access to necessary care and support for people with mental disorders (Chandra & Minkovitz, 2007; Hinshaw & Cicchetti, 2000).

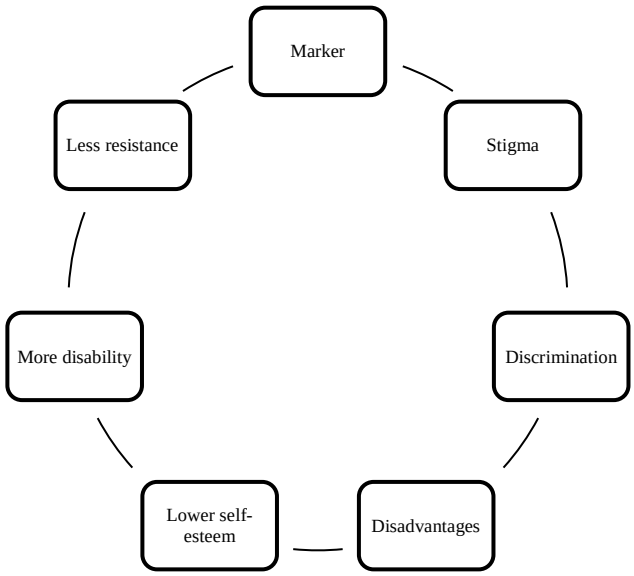
The other side of stigma is self-stigmatization, which is considered as a process of reducing self-esteem causing negative and destructive effect on the quality of life of people with mental disorders. They blame themselves for having a disease and hesitate to disclose their problems to others because of fear of possible negative reactions (O. F. Wahl, 1999).

A major role in developing and maintaining stigma belongs to low level of knowledge and awareness in mental health. The study of public prejudice towards people with mental disorders brought to light a significant influence of mass media (Hargrave & Livingstone, 2006). Studies among secondary school students in Germany showed that 65% of them had got information about mental illnesses from media (Schulze & Angermeyer, 2005). Despite certain rules related to highlighting mental health issues in media, authors suggested that the information was frequently offensive and had a negative impact on the image of people with mental disorders. People with mental disorders are often the object for ridiculing or condemnation in cinematography and especially animation (Martin, Pescosolido, & Tuch, 2000). The last fact points to the possibility of forming a stigmatization attitude towards people with mental disorders early in childhood.

Based on the available data and experience, the World Psychiatric Association adopted the Global Program against Stigma and Discrimination because of schizophrenia in 2005 (Sartorius & Schulze, 2005). It is based on a description of the process of forming and strengthening of stigmatization, that was called the "cycle of stigmatization of the individual" (Figure 2.1).

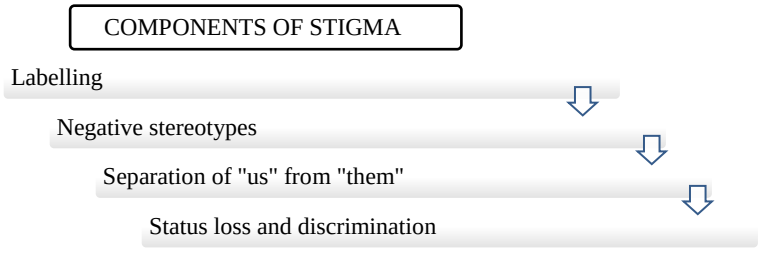
Cycle depicts the process of stigmatization from the beginning, when the person is identified by a certain "anomaly" or "label", represented by a mental disorder. Then overlay of information about this disease taken from past experience or by means of media takes place. This perception of disease can lead to discrimination by others, including the family, teachers, employers, etc. Self-stigmatization hinders treatment and recovery, that lead to a greater disability, lesser competitive ability in the society, lesser resistance and ability to protect own rights and interests. At the same time, the process of stigmatization can be interrupted at any stage by intervention aimed at stopping further stigma.

Figure 2.1. Cycle of stigmatization for the individual (Norman Sartorius)



Link and Phelan suggested slightly different concept of stigma. They highlighted emotional reactions as the main component of their model and also stated that stigma is a matter of attitude degree (B G Link & Phelan, 2001). As an example, they indicated, that while studying the stigmatization process some patients experienced alienation from their relatives, while others, on the contrary, received support. The same is true for the problem of employment, when some patients were recruited, while others were excluded from the list of applicants. Thus, the determining factor was the degree of negative or positive perception of the individual and his /her problems (Figure 2.2).

Figure 2.2. Conceptualizing Stigma (Link and Phelan, 2001)



In cases of stigmatization it is labeling a person was accompanied by a negative stereotype, division into "our" and "alien" groups and subsequent alienation followed by discrimination. The next important factor was the role of authority in the study of stigma. For example, when a psychiatrist or another mental health specialist as a representative of a higher status and authority, labels and ignores a client, he/she imposes his discriminatory perception on others.

Clear confirmation of mentioned above is the study, in which the specialists were tasked with identifying normal people, simulating the disease (Rosenhan, 1974). At the time of admission to various clinics all "pseudo-patients" complained of auditory hallucinations. All of them were admitted to the hospital and diagnosed with schizophrenia, despite the fact that right after admission their behavior was absolutely normal, they behaved as well as in normal life, and there were no complaints of voices. The medical personal accepted their every normal activity as an expression of the disease, relying only on the fact that psychiatrist diagnosed a mental disorder. Moreover, they all were discharged with a diagnosis of schizophrenia, despite the absence of symptoms. This experiment showed the presence of psychiatric label and its effect on others if the diagnosis is established by a person with authority.

2.2. Manifestations of stigma in the 20th century.

Throughout the human history people with mental disorders were exposed to variety of humiliations, discrimination, persecution and even extermination.

Curiously, the countries with the most various and effective health systems have experienced the problem of stigma "very acutely and painfully" during the last century.

For example, in the USA in 1915, the American Psychiatric Association called on the government to clampdown emigrants with mental disorders and imposed punishment of people, who helped them to arrive to country (Wagner, 1915).

Californian psychiatrist Popenoe called for sterilization of people with mental illness as a prevention method (H. Smith, 1930). In addition, in 1927, the Supreme Court considered a case of Carrie Bell, a woman with mental retardation, to determine the advisability of using sterilization in her case (U.S., 1927).

Another maybe the worst case, when stigma gave rise to extermination of thousands of people and destroyed millions lives, occurred in the heart of Europe during the Nazi period. Due to the prejudices of Nazi authorities the attitude of society became extremely cruel and even those

who might be supposed to protect the rights of patients – doctors and nurses – showed cruelty and violated the rights of people who they had to help (Fischer, 2012).

In the 1930s, when the fascists came to power in Germany, the Law for the Prevention of Hereditarily Diseased Progeny (Ost, 2006) was passed and all people with schizophrenia, mental retardation and other severe mental disorders were subjected to forced sterilization (Weikart, 2005). Although the exact number of victims as a result of these terrible measures cannot be calculated, depending on the sources, the number of sterilized people varies from 200 000 to 375 000 people (Sofair & Kaldjian, 2000; Weikart, 2005).

Despite the fact that fascism was defeated all around the world, prejudices and discriminatory attitude were present in the minds of people for a long time. It is well-known, in many European countries until the middle of the 20th century psychiatric hospitals served more for isolating patients and maintaining public safety rather than the place of offering necessary medical care.

Another example of stigma at the state level is the use of punitive psychiatry in the former Soviet Union. People suffering from mental disorders in the USSR were perceived as dangerous marginalized people who needed to be isolated from society. It is not by chance that during the Moscow Olympic Games in 1980 all persons who had psychiatric diagnosis and registered in Moscow were placed in closed psychiatric institutions. On the other hand, many political opponents of the communist regime were portrayed as mentally ill, consequently they were given a forensic psychiatric examination and involuntary inpatient treatment. Thus, in Soviet society stigma and discrimination against almost all aspects of mental health were cultivated (Birley, 2002; Van Voren, 2006).

One of the first fighters against stigma and proponents for changes in mental health care was Franco Basaglia, who became the founder of mental health reforms in Italy (Morzycka, Drozdowicz, & Nasierowski, 2015). He lobbied his ideas and in 1978 the law ("Legge 180") was adopted. The main focus of this law was voluntary treatment, patient`s rights and redirection of services from psychiatric hospitals to general hospitals and community centers. Similar processes began to take place in other Western countries.

Drawing conclusions from the past, it is necessary to remember and honor the memory of the victims of ill-treatment and do everything to prevent this from happening again. To do so health professionals do not have to betray the trust of the patients they served for (Fischer, 2012).

2.3. Stigma prevention.

Stigma has much in common with infection "damaging" the mind one person after another does not stop it. Without counteraction stigma spreads in the society and increases its range day after day. Thus, the fight against stigma should be conducted at all levels – from individual to population. Generally, methods of reducing the stigma can be divided into 3 branches: increasing the level of knowledge, contacting, and protesting (P. W. Corrigan & Penn, 1999).

As a rule, they are interrelated and often used together at all levels of impact. For example, analysis of the news and some media outlets has demonstrated that people with mental illnesses are often portrayed as negative and dangerous, isolated and useless, but also as guilty for their illness (McGinty, Kennedy-Hendricks, Choksy, & Barry, 2016; Pirkis, Blood, Beautrais, Burgess, & Skehan, 2006). In this case, the method of direct protest against the use of people with mental disorders in media in negative images and the protection of their rights is directly related to increasing the level of knowledge in persons responsible for broadcasting this information.

Another example of the complex use of techniques was applied in the US in 2016. As it is known, in 2016, the famous movie star, Oscar winner Robbin Williams, died as a result of suicide. The effect and emotions in consequence of this sad event caused a storm of discussions in the society and actor's mental health problems were frequently mentioned as the cause of suicide.

This case made possible to study the potential impact of media news on the death of celebrity, suffering from a mental disorder in the context of stigma. A survey of 350 adult citizens of the US included the questions divided into sections related to stigma, mental health promotion, knowledge about mental disorders, etc. The result of the study showed decreased level of stigma was in participants, increased motivation to help people suffering from depression, as well as a desire to improve knowledge in the field of mental health (Hoffner & Cohen, 2017). The study is the evidence that the correct presentation of information in the media can make positive changes in a very short time.

At the moment, there are large organizations in the world involved in uncompromising struggle for the rights of people with mental disorders. They are strong proponents for a fair treatment of psychiatric services users and pioneers in the developing of new programs of care. These organizations include National Alliance on Mental Illness (NAMI), Cole Resource Center, Psychiatric Survivors Movement and others. Among the most popular programs conducted by

NAMI are the educational programs Family-to-Family, Peer-to-Peer, Our Own Voice, as well as NAMI Connection and NAMI On Campus (Nami, 2013).

Interventions addressing stigma affect various areas, including the insurance system. As a rule, insurance payments and paid services include a large list of physical health problems whereas mental health problems are under-recognized (Haghighat, 2001). Prejudice of insurance companies against mental health causes that insurance holders with mental disorders (eg, depression) are less likely to visit appointed specialists, preferring to self-medicate, and seek a way out on their own. This attitude leads to increasing stigma and lower accessibility and affordability of care. The intervention in this segment is aimed on balancing between physical and mental health in the list of services covered by insurance, and also increasing level of awareness of clients about possible services in this respect.

Another example of effective intervention to reduce stigma towards people with mental disorders by law enforcement agencies was the work carried out in Colorado, USA. Training conducted by mental health experts, clients and their family members for the representatives of the courts and police officers helped to raise the level of mental health knowledge among the local authorities in the State of Colorado (Sartorius & Schulze, 2005). The acquired knowledge contributed to the fact that crimes and offenses related to mental disorders were correctly evaluated and appropriate medical interventions were used instead of imprisonment. Analysis of the results of pre- and post-testing in training participants showed a significant increase of the level of knowledge about mental health and the reduction of the stigmatizing attitude.

Despite the great changes since the beginning of de-institutionalization process around the world, there are still many unsolved problems in both the health care system and the society. Changes towards increasing of outpatient care and the development of various services without isolation from society instead of large psychiatric hospitals played positive role in reducing stigma. This process leads to an increase in number of people, suffering from mental disorders, who have been integrated into society. Such situation requires better understanding of mental health issues by the authorities. Otherwise, poor understanding, inadequate evaluation of behaviors and stigmatic attitudes from the courts and law enforcement agencies may further encourage criminalization of these individuals (Moore, Stuewig, & Tangney, 2016). Therefore, work with government officers is extremely important for the whole society.

2.4. Stigma among health workers.

One of the main tasks included in the WPA Action Plan for 2008-2011 and adopted by the WPA General Assembly is the reduction of stigma among mental health specialists and medical students. This document identifies the target groups that need to change attitudes towards people with mental disorders (Sartorius et al., 2010).

It should be noted that many doctors and nurses reveal an obvious stigma towards people suffering from mental disorders. Stigma towards people with mental disorders in the health system and among health professionals is considered to be a serious barrier for help seeking, treatment and recovery, and also reduces the quality of health care provided by them (Henderson et al., 2014).

A study in South Australia showed that mental health professionals were more pessimistic about the chances for recovery in people with schizophrenia and depression than the general public. Moreover, psychiatrists were less optimistic in their responses than nurses. Most experts based their forecast on the personal experience of treating people with mental disorders (Hugo, 2001). Fear and ignorance formed the basis for stigmatizing attitude towards mental illness in doctors-at-training in Croatia (Filipcić et al., 2003).

Stigmatizing attitude and inappropriate behavior in health care providers often lead to a decline in the quality of treatment, disruption of the therapeutic alliance between patients and service providers and reduction in the availability of care (Oliver, Pearson, Coe, & Gunnell, 2005).

The authors emphasize that stigmatizing attitude of general practitioners causes a sense of rejection and dissatisfaction at patients, which seem to be a major obstacle in obtaining medical care (P. Corrigan, 2004). It should be mentioned that mental health professionals can also share the same attitude towards their patients as their colleagues from other fields of medicine.

The Mood Disorders Society stated in its report that there was a noticeable stigmatization in medical institutions in Canada, by noting that people with mental illnesses “feel ignored in emergency departments and feel disrespectful to themselves from family doctors” (Patten et al., 2016).

2.5. Stigma in mental health policy.

Health authorities as representatives of a certain society share the same attitudes towards people with mental illness. Despite the stated priority of the mental health issues, mental health policy actually is not considered as important as decisions in the other fields of medicine.

Studies show that in many countries care of people with mental disorders is underfinanced, the service outcomes and the interests of patients are not taken into account.

It is obvious that stigma in health authorities hinders development of effective interventions, as well as modern services. Also stigma in health authorities results in insufficient training at both undergraduate and postgraduate levels.

Although some researches show that the study of psychiatry can contribute to a positive change in attitude towards users of psychiatric services, in other researches data show that this change in attitude affects only a small part of students.

Low prestige of profession of psychiatrist in comparison with other specialties and lack of desire to choose psychiatry as their future career are associated with the stigma.

Data obtained as a result of meta-analysis showed that general practitioners are recommended more often than psychiatrists in depression and less often in schizophrenia (Schnittker, 2008).

In many cases, parents of medical students have certain stereotypes about mentally ill patients and do not recommend their children to choose this specialty, which, in their opinion, is not “real medicine” (Wigney & Parker, 2008).

Online survey conducted in twelve countries revealed that 17% of psychiatrists perceive stigma regarding their profession as a serious problem.

Due to existing policies mental health professionals more often than other health professionals feel undervalued and prone to discrimination. To address this problem, the World Psychiatric Association established a task force which goal was to develop a “Guidance on how to combat stigmatization of psychiatry and psychiatrists” (Sartorius et al., 2010).

2.6. Stigma and mental health reform.

Over the last 40 years, there were major reforms in mental health which produced some positive results. In fact, the quality and quantity of mental health services differ from country to country. Even in the same country there is a big difference between regions in development of mental health care.

The activities addressing stigma within mental health system may be divided into certain interrelated groups. For example, in the UK national service standards include the following forms of tackling stigma: 1) Promotion of mental health and reduction of stigma; 2) Access to primary

care services; 3) Effective community services for people with severe mental illness; 4) Caring for caregivers (Joseph & Birchwood, 2005).

Regardless the type of treatment (e.g. psychopharmacological intervention, psychotherapy and psychosocial rehabilitation) stigma reduces efficiency of all types of care due to avoidance of help seeking or poor compliance observed in patients experiencing self-stigma. In a study by Clement et al., stigma hold the fourth place among the barriers on the way of obtaining help by people, suffering from mental disorders (Clement et al., 2015). Because of self-stigma and fear of losing position in society, people who need a professional help tend to avoid it (Gulliver, Griffiths, & Christensen, 2010; B G Link & Phelan, 2001; Taghva et al., 2017; Thornicroft, 2008).

Stigma in mental health professionals and other health workers towards patients with mental disorders creates serious obstacles in accomplishment their responsibilities. In addition stigma disturbs the normal psychological atmosphere at workplace (Knaak, Mantler, & Szeto, 2017).

According to Jordanian researchers who studied self-stigma in patients with schizophrenia, depression and anxiety disorders stigma was caused by three factors - prejudiced stereotypes, personal responsibility for the disease and perceived impossibility to recover (Hasan & Musleh, 2017). It may be proposed that the third factor is related to service providers. This perception of mental disorders by people and the fear of being "labeled" by society is one of the main reasons of ignoring early access to psychiatric care. Also, people in Jordan prefer to see a neurologist rather than psychiatrist, claiming that this is more affordable and less "shameful."

In developing countries, people with severe mental disorders, such as schizophrenia, feel a social stigma and try to hide their problem. Therefore, patients and their families often reject the specialist care and seek for help from "healers" without a medical education (Marthoenis, Aichberger, & Schouler-Ocak, 2016).

The study of Sanyal and Das conducted in India showed how patients chose the care due to their understanding of the nature of mental disorders. The most common explanation of the cause of diseases indicated by the patients was stress (25.5%) and witchery (23.5%). The examined persons visited mental health specialists in 27.5% of cases, whereas consultations of healers were received by 29.4% of patients (Sanyal & Das, 2017).

Some studies in the Middle East and Arab countries have demonstrated that the stigmatizing opinions and attitudes towards mental disorders are the main barrier for inclusion into psychosocial rehabilitation programs (Aloud & Rathur, 2009).

Supernatural beliefs about the etiology of mental disorders can cause stigma in various ways (Robin E. Gearing et al., 2015). In turn, explanation of the nature of mental disorder by changes in the body's biological process, which is often observed in Western culture, leads to the fact that people are more likely to seek help from mental health specialists and clinics (Macleod, Elliott, & Brown, 2011).

Another reason for avoiding care is the stigma associated with severe mental illness and the fear of being labelled when a frightening diagnosis is detected. In addition unwillingness to be addicted to drugs create a barrier to treatment (Fung, Tsang, & Cheung, 2011; Sibitz, Unger, Woppmann, Zidek, & Amering, 2011).

A number of studies have revealed a preference for choosing care type in favor of psychotherapy in comparison with drug treatment. One of the reasons for this was a less severe stigma towards psychological interventions (R. E. Gearing et al., 2012).

Patients who have been diagnosed with schizophrenia, bipolar disorder or depression are initially prone to delay their treatment. All this is accompanied by a variety of reasons, for example, lack of knowledge about mental disorders or not unawareness about access to treatment (Henderson, Evans-Lacko, & Thornicroft, 2013), desire to solve their problems independently, etc. (van Beljouw et al., 2010), attribution these symptoms to physical illness or insomnia (Tanskanen et al., 2011), inadequate insight about his or her mental status (Bitter, Feher, Tenyi, & Czobor, 2015). Despite a great number of different reasons, they all are somehow are associated with stigma.

Stigma as a barrier in providing of professional help leads to severe negative consequences affecting even high-income countries, as people who need mental health care ignore necessary treatment (Thornicroft, 2008; Wang et al., 2007). In its turn not rendered timely care may result in decrease of neurocognitive abilities and quality of life (Amminger, Edwards, Brewer, Harrigan, & McGorry, 2002; Gaynor, Dooley, Lawlor, Lawoyin, & O'Callaghan, 2009; (Harrigan, McGorry & Krstev, 2003), as well as in social isolation (Barnes et al., 2008), an increase in the period of first hospitalization (Penttila et al., 2013) and neurostructural changes in the brain (A.K., M., &

R., 2011; Fusar-Poli et al., 2013). The other negative effects include increased risk of substance misuse (Lagerberg et al., 2010) and suicide (Nery-Fernandes et al., 2012).

In future studies, much attention should be paid to assessing "expectations from treatment" in patients who have completed treatment.

2.7. The experience of studying the level of stigma towards people with mental disorders in the population of Azerbaijan.

The research community conducted large number of studies related to stigma towards people suffering from mental disorders. They contributed to a better analysis of this problem and development of more effective methods for combating stigma. However, most of these studies were conducted in Europe and the USA. The problem of stigma towards people with mental disorders is not well studied in Azerbaijan and requires more attention. The research described below is one of the first studies focusing on stigma and intending to highlight real situation and determine further perspectives.

The study was conducted within the project "Strengthening the role of mental health users in 5 regions of Azerbaijan (2012)" and it considered public attitudes towards people with mental disorders in Azerbaijan. This project was a result of cooperation between the Lithuanian Office of "Global Initiative on Psychiatry" and the local non-governmental organization "Initiative for the sake of development."

996 respondents who represented a population of five regions (Baku, Ganja, Sheki, Lankaran, Guba) participated in the study. The inclusion criterion was a voluntary consent to answer the survey and the exclusion criterion was being mental health professional or service user.

Analysis of socio-demographic data showed that females (58.8%), young people (69.6%) and married individuals (55%) predominated among the respondents. The majority of respondents had secondary of higher education and worked in governmental sector.

As answers to the question *"What do you think is typical of a person with mental health problems?"* showed a large number of respondents (49.8%) believe that people with mental disorders are not responsible for their behavior, in addition, 33.7% of respondents consider people with mental disorders to be inclined to aggressive actions or dangerous to others. At the same time, 44.8% of the respondents suggested that people with mental disorders can have a disturbance of thinking, behavior or emotions.

The respondents' answers revealed a more paternalistic attitude towards people with mental illnesses. In particular, 36.4% of the respondents believe that such patients are completely isolated from the society, 45.1% think that these people are not able to get education, 37.3% are convinced that people with mental disorders should be constantly kept in special institutions, and 22.7% believe that they are not able to work and earn money. In addition, a significant number of respondents suggested the strict judgments 'on the impossibility for the patients to get married and have children' (36.8%) and 'the need for treatment exclusively in specialized institutions' (45.9%), as well as 'necessity and involuntary treatment' (40.2%).

Although there was similarity between respondents in their opinions about the lives of people with mental disorders, the study identified some differences in answers depended on socio-demographic variables. Female respondents showed a greater degree of tolerance in the issue of the ability of mentally ill to marry and have children. Survey participants, who had relatives with mental disorders, better recognized possibility for patients to live in families, rather than in closed hospitals.

Referring to the main sources of information on mental health issues, 27.3% of respondents indicated the media, 26.6% received information from friends, relatives and colleagues, 11% of respondents pointed information provided by films and books including the experts in the field of mental health. Among the respondents who noted rejection and unwillingness to receive information about mental health issues (2.6%), the majority were persons with primary (18.8%) or incomplete secondary education (18.5%)

This study revealed that issues related to the ability of mentally ill people to marry and have children caused the negative emotional reaction and social aversion. These statements caused strong rejection in almost 65% of the survey participants. Also, many respondents disagreed with the statement *"Most people are ready to learn / work in the same team with people with mental health problems"*.

The study showed that the attitude to the social competence of patients does not depend on gender, education, marital status and place of residence of respondents. However, older persons are more likely to recognize the fact that people with mental disorders can be involved in desirable social activities and fulfill their social functions. The authors suggested that life experience facilitated more tolerant attitude of elderly people to vulnerable groups of the population.

Statistically significant differences between male and female respondents were revealed in relation to unpredictable actions of persons with mental disorders. Women were more likely to see the threat to others from patients. Probably this is due to the fact that female respondents have great caution about violent actions, as well as the need for security.

The study revealed that the married respondents expressed a more positive attitude towards the protection of the rights of persons, suffering from mental disorders.

The study found that the more respondents were informed about the real living conditions of people with mental disorders, the more they recognized the ability of patients to social adjustment.

The positive correlation between the knowledge of respondents and the attitude towards the rights of people with mental disorders proves that a greater familiarity with the patients' lives implies a better attitude towards their civil rights and interests.

Answering the question *"How many people in your life are experiencing serious mental health problems?"* only 10.5% were able to indicate the correct answer (1 out of 4). The findings indicate that 90% of people do not have reliable information about mental disorders.

This study established three main factors that have a negative impact on attitude towards people with mental disorders. The first of these factors is misbeliefs about the social competence of patients. Another factor is the perception of patients, as to persons with unpredictable behavior. The third factor is under-recognition of rights of people with mental disorders. It is obvious that addressing these factors will improve the situation in terms of stigma reduction.

Chapter 3. THE OBJECTIVES OF THE STUDY

The primary aim of the study is to determine the effectiveness of training fighting stigma and improving attitudes of mental health professionals towards people with severe mental illness in Azerbaijan.

Specific goals include:

1. To measure the stigma level among nurses working in psychiatric hospitals and determine the relationship between the stigma level and socio-demographic variables.
2. To determine the influence of training on attitudes, knowledge and social distancing towards people with mental disorders.
3. To evaluate sustainability of changes in attitudes, knowledge and social distancing over six-month follow-up period
4. To develop recommendations based on the collected data.

Chapter 4. METHODOLOGY

4.1. Study Setting

This study was conducted in the following institutions:

Sheki-city Psychiatric Hospital is an interregional in-patient facility, located in the North of the country 305 km. far from Baku. It serves 6 northern regions of the country (Balaken, Zagatala, Gakh, Sheki, Oghuz, Gebele) with a total population of about 610,000 people. The hospital is designed for 100 beds and it has 3 departments, 2 of which (male and female) are inpatient and one is outpatient departments. There are 3 psychiatrists and 21 nurses working in the hospital. The list of provided services includes inpatient treatment of acute and/or severe psychiatric disorders, as well as outpatient psychiatric treatment of adult patients with mental disorders.

Ganja-city Psychiatric Hospital is also an interregional hospital located in the West 375 km. far from Baku. The hospital serves 10 regions (Goygol, Goranboy, Dashkesen, Gedebey, Shamkir, Samukh, Yevlakh, Terter, Aghdam, Berde) and two big cities (Ganja, Mingechevir) with a total population of about 1,600,000 people. The hospital is designed for 200 beds. 6 psychiatrists, 1 therapist, 1 psychologist and 28 nurses work in the hospital. It has 5 departments - 2 male and 2 female inpatient departments and a day-care department.

Psychiatric Hospital No 1 of the Ministry of Health is the largest psychiatric hospital in the country. It is located in Baku 30 km. far from the city center. The hospital is designed for 2030 beds distributed between 31 departments. It provides services for people living in Baku, as well as for patients from other regions. The hospital staff includes 48 psychiatrists, 21 other physicians, 10 clinical psychologists, 94 nurses, 30 job coaches, 222 technical workers and 423 orderlies. The list of provided services includes inpatient and outpatient treatment of various mental disorders in children and adults including addiction. There are new programs on psychosocial rehabilitation, psychotherapy, day-care treatment and family involvement launched in this hospital.

4.2. Research Questions and Hypotheses.

Research Question 1: Is there a direct relationship between the socio-demographic variables and the level of stigma in nurses, working in psychiatric hospitals?

Hypothesis 1.1: Socio-demographic variables are associated with the level of stigma

Hypothesis 1.0: Socio-demographic are not related to the level of stigma

Research Question 2: Will the anti-stigma training participants show positive changes in knowledge in terms of decreased stigma towards people with mental illnesses?

Hypothesis 2.1: Anti-stigma training reduces stigma towards people with mental illness knowledge in the nursing staff

Hypothesis 2.0: Anti-stigma training does not affect stigma towards people with mental illness in the nursing staff

Research Question 3: Will the training participants maintain improved attitude towards people with mental illness six months after anti-stigma training?

Hypothesis 3.1: The effect of training on reducing stigma remains sustainable six months after the training

Hypothesis 3.0: The anti-stigma effect decreases six months after the training completion

4.3. Study Participants

The sample represented nurses staff providing in-patient services for adult patients with acute or severe mental illness admitted in psychiatric hospitals.

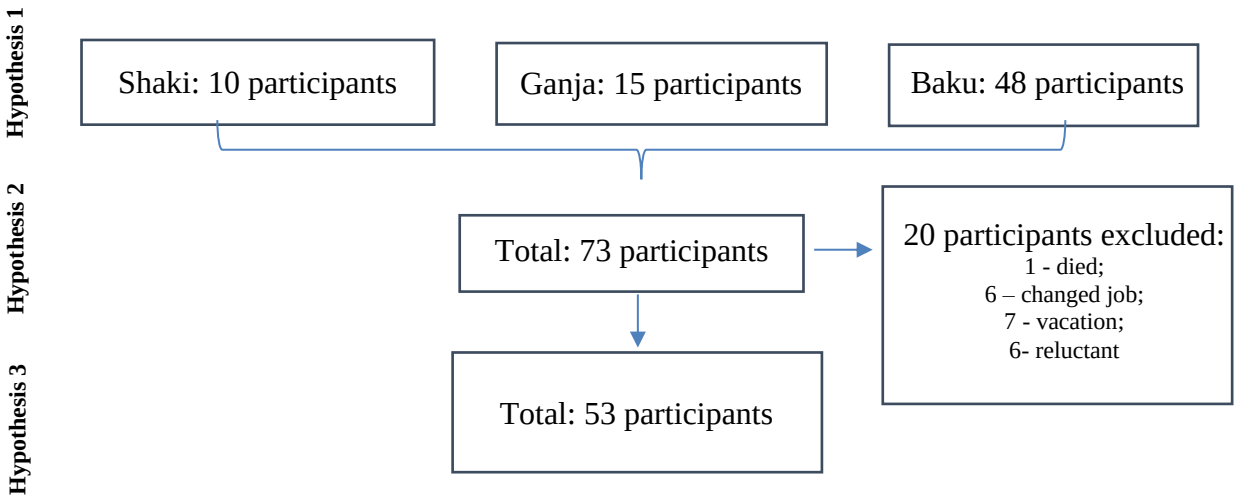
The inclusion criteria are the followings:

- No less than one year of professional experience in mental health
- Non-participation in previous anti-stigma trainings or campaigns
- Active involvement in in-patient care provision
- No less than six months before retirement age
- Free consent and ability to take part in this research

Thus 73 participants were recruited and baseline assessment of their attitudes in term of stigma was conducted before the training. The second assessment was conducted just after the training. The follow-up assessment was conducted among 53 out of 73 participants six months after the training. Among twenty nurses who did not participate in the follow-up assessment one person died, six changed their workplace, seven were on vacation, yet six nurses did not provide consent to participate in the study.

Data of dropped out participants were excluded from the final analysis. (Figure 4.1)

Figure 4.1. Study Participants



4.4. Procedure

The present study was approved by the Ethical Committee of the Azerbaijan Psychiatric Association. All participants gave their consent to participate in the study. To ensure the anonymity and confidentiality of the participants of the special provisions were developed. The results of the survey were submitted to the Mental Health Center for further proceeding and analysis.

The study was conducted in several stages. The first stage included reviewing literature, developing and preparing training materials aimed at improving knowledge and reducing stigma among nurses, selecting and adapting research tools and selecting the target facilities.

The second stage included the collection of socio-demographic data of 73 participants and their baseline assessment, as well as the training and post-training assessment. Three-hour training was conducted by a principal investigator at selected hospitals in a separate training room. To exclude any influence of the manager staff of the hospital or other persons it was not allowed someone except the participants and the trainer themselves to enter the room. Demographic data of the participants were collected before the training by means of a special questionnaire. Each participant was given an identification number to be indicated in the questionnaires and which remained the same at all stages of assessments.

In case of insufficient understanding of any question included into the self-report questionnaire, an interviewer provided necessary explanations on individual basis. The average

time required to complete all the questionnaires at the first evaluation was approximately 60 minutes. Participants could not communicate during filling in the questionnaires, in order to minimize influence of one participant to another.

A training course focusing on increasing knowledge and reducing stigma among nurses was given after the baseline assessment. At the end of the training, the participants had an opportunity to ask questions to their trainer. Then they underwent post-training assessment.

The third stage included proceeding of demographic data, as well as the data from initial assessment and the second assessment. During this stage, we investigated the relationship between the socio-demographic variables and level of stigma. Relevant statistical analysis of data obtained from 73 participants was carried out.

At the fourth stage follow-up assessment was conducted six months after the training. It included the survey among 53 nurses previously participating in the training. All the survey participants were asked to fill in the questionnaire they had been familiar with.

At the final stage a comparative analysis of the results of three assessments was provided, and the thesis was prepared.

Two research designs were used in this study - a cross-sectional correlation study design was applied for investigating relations between socio-demographic variables and stigma, and quasi-experimental design was used to evaluate training effectiveness. The study neither provided randomization nor included a control group. Respondents did not receive any incentives or rewards for their participation in the study.

4.5. Training

The training aimed at increasing knowledge and reducing stigma among nurses represented a three-hour educational program consisting of three interrelated parts.

In the first part of the training, the concept and the development of stigma in a historical context were introduced to participants. During the training, the causes of stigma and the biopsychosocial model were explained in detail. Participants had the opportunity to ask questions about the topic or in the case they encountered an unknown term. The training program also included topics about existing "myths" associated with mental disorders.

The "three elements" of stigma were explained: the lack of knowledge, the problem of relations and problems in behavior. During the presentation, the stigma process in an individual

was gradually demonstrated. In the process of interactive communication, participants discussed manifestations of stigma in such areas as family, work, society, healthcare system, media, and attitudes towards oneself. In the conclusion of the first part of the training, the evolution of care for people with mental disorders and "Ten ways to combat stigma" was described.

The second part included providing a contribution of certain mental disorders, such as schizophrenia, bipolar affective disorder, depression, and post-traumatic stress disorder and dementia to developing stigma were discussed. In addition general symptoms and forms of treatment, epidemiological data, predictors of disease outcomes and risk factors were demonstrated.

The third part of the training included a role-play and two small group tasks. The role play was conducted with several volunteers from the training participants. The first game, which we conventionally called a "shortcut", was that a sticker with an inscription was glued to the participants' forehead. The main rule of the game was that the player did not know what was written on his sticker, but he or she saw the inscriptions of the remaining players. Half of the players were glued stickers with the inscription of a certain mental illness (For example: schizophrenia, mental retardation, etc.) or "negative" features of a person (For example: a fool, a freak, etc.). Another half of the players got a sticker with a "positive" characteristic (for example: honest, attentive, etc.). This was done to strengthen distinction between participants. According to the rules of the game, all participants were sitting in a circle and were given a general team task (for example, "you must prepare a party in a restaurant for a large company"). At the same time, everyone should try to take as many functions as possible to prepare for the holiday, with which he or she in their opinion will cope. The team took turns to make decisions with respect to each player whether they agree or refuse the player could be assigned the task based on the inscription indicated on his/her sticker. At the same time the team should not reveal the true reason for the refusal, if it is connected with the diagnosis on the tag. As a result, after the completion of functions distribution and tasks between players, as a rule, the team assigned most of the tasks to people with "positive" inscriptions. After that, the trainer asked participants with mental diagnoses or negative characteristics of the stickers indicated "what did you feel when you were not assigned any cases?". Most people reported they felt bad, isolated, insecure. Some expressed their feelings with such words as "outcast", "useless" and "humiliated." Almost all of this caused internal discomfort and

aggression. This game helped the participants in the training to understand better what other people felt when they faced stigma in every day life.

In the first thematic task, various famous people appeared on the screen, enjoying worldwide fame and respect, and the training participants had to suppose who of presented persons had an illness and what the illness was. This task allowed showing how positive examples can affect general attitude to a particular mental disorder.

In the second task, during the training, participants were presented with a fictional story about a person named Ahmed, who was accused of committing a murder. (The name Ahmed is a widely used male name in Azerbaijan, it can often be found in folklore and frequently it symbolizes the "ordinary citizen" of the country. This character is a kind of analogue of the American version of John Smith). Training participants did not know that this story is fictitious and they read out scraps from non-existent newspapers. They were offered to discuss the story and answer the question whether they considered him guilty. Gradually, the text of the fictional newspaper article was added with some new details about this guy's life. So first it was said that the murder was committed in Ahmed's house. Then it was added that he suffered from mental disorder. After that, it pointed out he had schizophrenia and previously received psychiatric treatment. At the end of the story, a fictional police report was added that Ahmed committed a murder against robbers to save his family, he was acquitted and released in the courtroom. During this task, the opinion of the participants changed with each new portion of information about Ahmed. After each next portion of information about Ahmed, the trainer recorded the number of people who believed that he was "guilty." As a result, a diagram drawn by trainer showed how the number of people "condemned" Ahmed grew and reached its peak when they found out that maybe he had schizophrenia and quickly declined after the police report stating that he had saved his family. The goal of this task was to show that people could come to wrong conclusion based on false stereotypes.

4.6. Instruments

Community Attitudes toward Mental Illness (CAMI)

Over 35 years the CAMI scale has been widely used in studies investigating the stigma in mental disorders (Arboleda-Flórez & Sartorius, 2008; Cotton, 2004; Krameddine, DeMarco,

Hassel, & Silverstone, 2013; Locke, 2011; Morris et al., 2012; Taylor & Dear, 1981; Taylor, Dear, & Hall, 1979; Thornton & Wahl, 1996; Otto F. Wahl, 1993; Wolff, Pathare, Craig, & Leff, 1996).

The CAMI included 40 items evaluated on 5-point Likert scale. The CAMI has four subscales representing dependent variables in the current study: *Authoritarianism, Social Restrictiveness, Benevolence and Community Mental Health Ideology*. Likert type responses are provided for each item and scored accordingly (5=strongly agree, 4= agree, 3= neutral, 2 = disagree and 1=strongly disagree). There are 10 items belong to each subscales, and 5 of these items are reverse-coded. Items for each subscale are summed together to provide one score ranging from 10-50. A mean score is then calculated for each subscale (Locke, 2011).

Social Distance Scale (SDS)

The SDS has been used for studying stigma for many years. It can clearly estimate a respondent's desire to have a relationship with a person who reveals certain characteristics (disease, race, conviction, religion, etc.) depending on the degree and form of the relationship (for example, whether one is a relative, a neighbor, an employee, a lay person, etc.) (Bogardus, 1933; Bruce G. Link, Yang, Phelan, & Collins, 2004). Usually, participants are asked to accept or decline desire to interact with this person. In the current study, four possible states with the same degrees of communication were used. As a result, 20 questions were obtained, divided into 4 possible states in 5 types of relationship. The following states include: 1) a person suffering from schizophrenia; 2) a person suffering from depression; 3) a person suffering from substance use; 4) a person who has previous conviction. The types of relationship include: 1) a person as a relative; 2) a person as a close friend; 3) a person as a neighbor; 4) a person as a colleague; 5) a person as a lay individual

Schizophrenia Knowledge, Attitudes and Perceptions Scale (SKAPS)

The SKAPS measures *Perceptions, General Attitudes and Knowledge* of schizophrenia and other mental disorders (V. Smith, Reddy, Foster, Asbury, & Brooks, 2011). The knowledge subscale consists of 12 true/false items about schizophrenia and other mental health problems. The attitudes measure consists of 13 items regarding tolerance towards people with schizophrenia or other mental disorders (Benov et al., 2013), which are assessed with five-point Likert-scale (ranging from strongly agreeing statement to strongly disagreeing statement).

Since the CAMI, SDS and SKAPS were used for the first time in Azerbaijan, we translated them in Azerbaijani language and adjusted. The process of translation and adaptation included the following stages:

1) The scales were translated from English into Azerbaijani language by a professional translator with experience of mental health text translation. The translation was later discussed with mental health professionals from the National Mental Health Centre.

2) Back-translation of the scales into English was made by an independent translator and compared with original versions by a native English speaker. The necessary revisions of disputed items in the Azerbaijani version were addressed

3) Azerbaijani version of the instruments was reviewed by experienced mental health professionals and service users. Necessary modifications were provided in this respect.

4.7. Statistical analysis.

The data was analyzed using the Statistical Package for Social Sciences version 23.0 (IBM SPSS Statistics Version 23).

The linear simple regression was used in order to determine an association between the attitudes toward patients (stigma, knowledge and distancing) and socio-demographic indicators.

Friedman's test was used to compare results of baseline, post-training and follow-up assessments. The choice of this test was due to lack of information about normal distribution of stigma, knowledge and distancing indicators, since the study was performed on a conventional sample.

All tests were two-tailed and the level of significance was set at $p<0.05$.

Chapter 5. RESULTS

5.1. The relationship between sociodemographic characteristics and Attitudes, Knowledge and Social Distance.

The first part of the study involved 73 nurses primarily females (Table 5.1). The average age of participants was 45. Three quarters of them were married at the time of the study. The average period of work experience in mental health service was about 13 years. Most participants reported the level of social status as average. Only 3 participants had a relative with mental disorder. Almost a third of participants had night shifts and approximate number of shifts was eight days per month.

Table 5.1. Sociodemographic characteristics of the study participants

Variable	Total	Baku	Sheki	Ganja
Gender N (%)				
Female	62 (84.9)	41 (85.4)	8 (80)	13 (86.7)
Male	11 (15.1)	7 (14.6)	2 (20)	2 (13.3)
Age M (95% CI)	44.6 (41.84-47.37)	43.81 (40.43-47.2)	43.3 (35.28-51.32)	48.0 (40.76-55.24)
Marital status N (%)				
Single/never married	13 (17.8)	9 (18.8)	1 (10)	3 (20)
Married/cohabitation	54 (74)	35 (72.9)	9 (90)	10 (66.7)
Divorced/separated	1 (1.4)	1 (2.1)	-	-
Widow/er	5 (6.8)	3 (6.2)	-	2 (13.3)
Years of experience M (95% CI)	12.82 (9.92-15.72)	12.33 (8.42-16.29)	13.2 (5.74-20.66)	14.13 (8.28-19.99)
Unit N (%)				
Female unit	16 (21.9)	12 (25.0)	1 (10)	3 (20.0)
Male unit	40 (54.8)	28 (58.3)	1 (10)	11 (73.3)
Mixed unit	17 (23.3)	8 (16.7)	8 (80)	1 (6.7)
Socioeconomic status				
Lower	1 (1.4)	-	-	1 (6.7)
Middle	66 (90.4)	44 (91.7)	8 (80)	14 (93.3)
Upper	6 (8.2)	4 (8.3)	2 (20)	-

Family members with MI				
Yes	3 (4.1)	2 (4.2)	-	1 (6.7)
No	70 (95.9)	46 (95.8)	10 (100)	14 (93.3)
Number of nights shifts per month M (95% CI)	8.44 (7.09-9.8)	8.25 (5.65-10.85)	- -	8.82 (6.9-10.75)

Table 5.2 shows the relationship between socio-demographic characteristics and attitudes toward patients assessed with the CAMI scales.

The demographic variables did not reveal statistically significant difference on *Authoritarianism* subscale. Thus, common beliefs about people with mental illness were not related to socio-demographics of respondents.

However, a negative relationship between *Benevolence* and marital status was identified. It is likely negative that this correlation is due to changes in their priorities people obtain a new role of a spouse and subsequently a parent. At this stage people may be involved in various family issues, while people with mental disorders with their needs and problems are considered as an "extra burden" for a family and society .

A stronger correlation can be observed between socio-demographic indicators such as social status, years of experience, number of night shifts and *Social Restrictiveness*. The relationship between social status and *Restrictiveness* can be explained by the fact that higher living standard as well as lower social competition contribute to developing of stigma. At the same time, more experience in mental health enables staff to interact more with patients that improves the patients' perception as people with disabilities. The negative relations between number of night shifts and the *Social Restrictiveness* indicate a certain order to manage patient behavior at bedtime. In this case, the use of the *Social Restrictiveness* helps to maintain a certain regime in the facility they are responsible for. In addition, night shift workers have a lower status in a hospital leading to a greater degree of social restrictiveness.

The analysis of the data did not reveal the relationship between socio-demographic characteristics and *Community Mental Health Ideology*. Despite the fact that the survey was conducted among staff providing institutional care, their knowledge of issues related *Community Mental Health Ideology* scale was relatively high (Figure 5.1).

Table 5.2 Sociodemographic characteristics and CAMI subscales

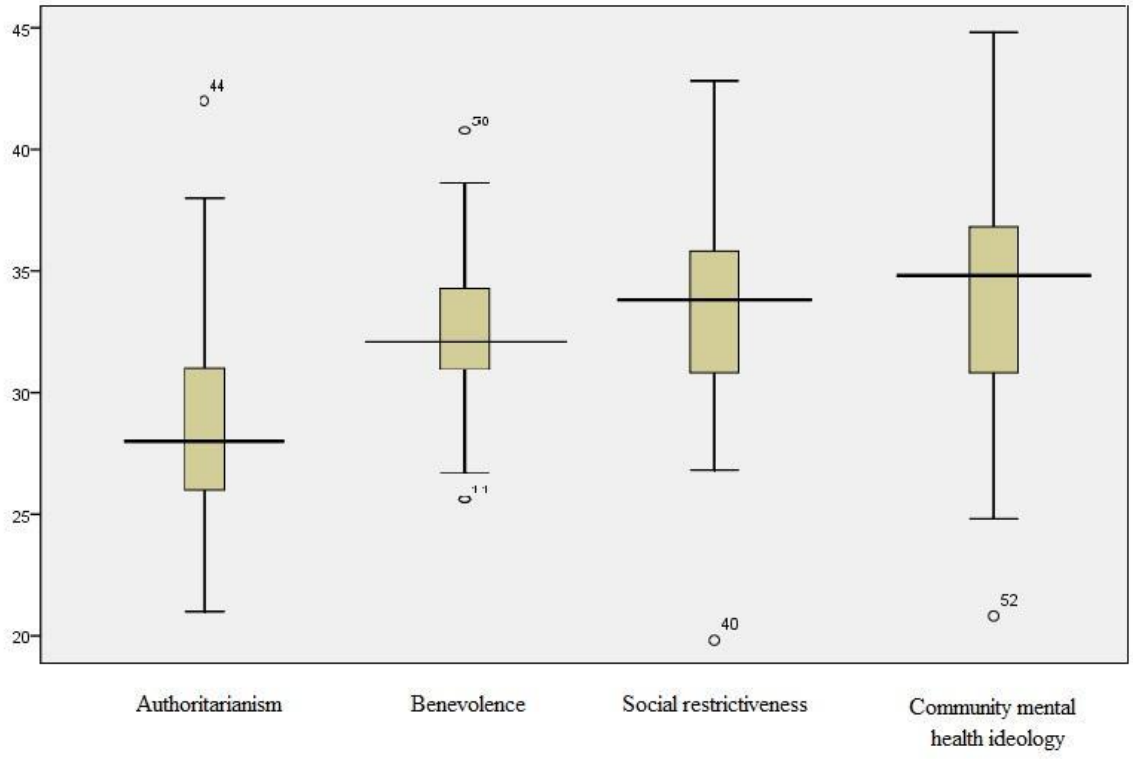
Authoritarianism	Standardized Coefficients			
	Beta	t	Sig.	M (95% CI)
Work place	.166	1.417	.161	.66 (-.580 – 3.432)
Age	-.157	-1.340	.184	44.6 (-.135 – .0027)
Sex	-.096	-.813	.419	.85 (-1.59 – 3.781)
Marital status	- .08	-.680	0.495	.74 (-2.940 – 1.445)
Social status	.070	.591	.557	1.93 (-2.244 – 4.133)
Family members with mental illness	-.084	-.711	.479	.004 (-6.573 – 3.116)
Years of experience	-.180	-1.545	.127	12.82 (-.136 – .17)
Unit (department)	-1.42	-1.211	.230	0.22 (-3.712 – .907)
Number of night shifts	.174	.883	.386	8.44 (-.247 – .618)

Benevolence	Standardized Coefficients			
	Beta	t	Sig.	M (95% CI)
Work place	-.105	-.886	.379	.66 (-2.143 – .825)
Age	-.113	-.959	.341	44.6 (-.88 – .031)
Sex	-.055	-.463	.645	.85 (-2.435 – 1.517)
Marital status	-.254	-2.210	.03	.74 (-3.291 – -.169)
Social status	.201	1.725	.089	1.93 (-.309 – 4.285)
Family members with mental illness	.144	1.229	.223	.04 (-1.353 – 5.706)
Years of experience	.092	.719	.439	12.82 (-.35 – .079)
Unit (department)	-.154	-1.316	.192	.22 (-2.807 – .575)
Number of night shifts	.123	.621	.541	8.44 (-.278 – .518)

Social restrictiveness	Standardized Coefficients			
	Beta	t	Sig.	M (95% CI)
Work place	-.023	-.193	.848	.66 (-2.279 – 1.877)
Age	.057	.485	.629	44.6 (-.063 – 1.877)
Sex	.046	.39	.698	.85 (-2.218 – 3.292)
Marital status	.003	.026	.979	.74 (-2.218 – 2.277)
Social status	.247	2.152	.035	1.93 (.251 – 6.580)
Family members with mental illness	-.209	-1.804	.075	.04 (-9.253 – .463)
Years of experience	.231	2.003	.049	12.82 (.000 – .156)
Unit (department)	-.54	-.454	.651	.22(-2.922 – 1.839)
Number of night shifts	-.425	-2.346	.027	8.44 (-1.046 – -.068)

Community Mental Health Ideology	Standardized Coefficients Beta	t	Sig.	M (95% CI)
Work place	-.003	-.029	.977	.66 (-2.474 – 2.402)
Age	.067	.568	.572	.66 (-2.474 – 2.402)
Sex	.163	1.390	.169	.85 (-.967 – 5.416)
Marital status	.119	1.014	.314	.74 (-1.287 – 3.949)
Social status	-.018	-.150	.881	1.93 (-4.119 – 3.543)
Family members with mental illness	-.012	-.101	.920	.04 (-6.123 – 5.533)
Years of experience	.091	.772	.443	12.82 (-.057 – .129)
Unit (department)	.075	.637	.526	.22 (-1.897 – 3.680)
Number of night shifts	.036	.178	.860	8.44 (-.558 – .664)

Figure 5.1. CAMI

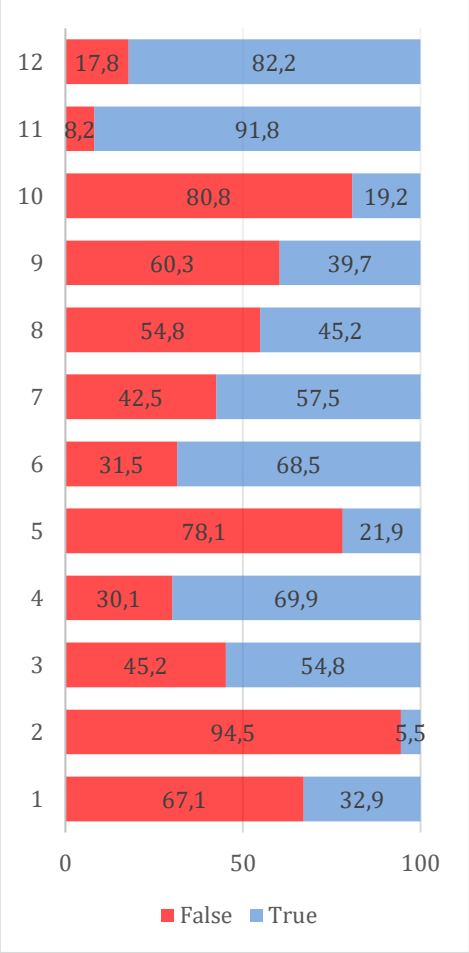


The analysis of the data obtained with the SKAPS made it possible to determine the level of *Knowledge* of nurses about the nature of mental disorders and the *Perception* of people with mental illnesses (Table 5.3).

However, the study did not reveal any relationship between the socio-demographic data and the level of *Knowledge*. It should be noted that the level of *Knowledge* was not high enough.

The total number of answers related to *Knowledge* was divided almost equally (true answers - 49%, false answers 51%). At the same time, many respondents answered incorrectly to many questions. For example, 94.5% of the respondents answered “Yes” to the question that "people with schizophrenia suffer from multiple personality disorder." Yet, 80.8% noted that "In general, people who develop schizophrenia have low scores on IQ tests", and 78.1% indicated that "Individuals with schizophrenia must be institutionalized in order to protect society." (Figure 5.2)

Figure 5.2 SKAPS Knowledge Subscale True/False questions.



12 Schizophrenia affects a person’s cognitive abilities.

11 Bipolar disorder is characterized by emotional highs and lows that change quickly and without apparent reason.

10 In general, people who develop schizophrenia have low scores on IQ tests.

9 Through treatment and medication, schizophrenia can be cured.

8 All people with schizophrenia experience visual or auditory hallucinations.

7 Psychosis is the complete loss of reality and rational thoughts.

6 Schizophrenia can be caused by substance abuse.

5 Individuals with schizophrenia must be institutionalized in order to protect society.

4 Catatonic symptoms include rigid posture, lack of awareness and decreased reactivity to the environment.

3 The social networks of individuals with schizophrenia consist primarily of family members.

2 People with schizophrenia suffer from multiple personality disorder.

1 In general, individuals with schizophrenia behave violently.

The maximum percentage of correctly answered questions scored the following assumptions: "Bipolar disorder is characterized by emotional highs and lows that change quickly and without apparent reason" - 91.8%; "Schizophrenia affects a person's cognitive abilities" -

82.2%; "Catatonic symptoms include rigid posture, lack of awareness and decreased reactivity to the environment" - 69.9%.

We can assume that the correct answers were based on the clinical experience with patients, while the questions that were given the wrong answers required deeper knowledge about the causes of mental illness or familiarity with the norms of existing mental health legislation.

The analysis of the data revealed a relationship between the region where survey participants worked and *Perception*. Living in the capital correlated with a more positive perception of people with mental disorders. This can be facilitated by factors such as more frequent participation in various educational programs, cooperation with opinion leaders and application of a wider range of modern services (rehabilitation, occupation therapy, etc.) associated with close interaction with people with mental disorders

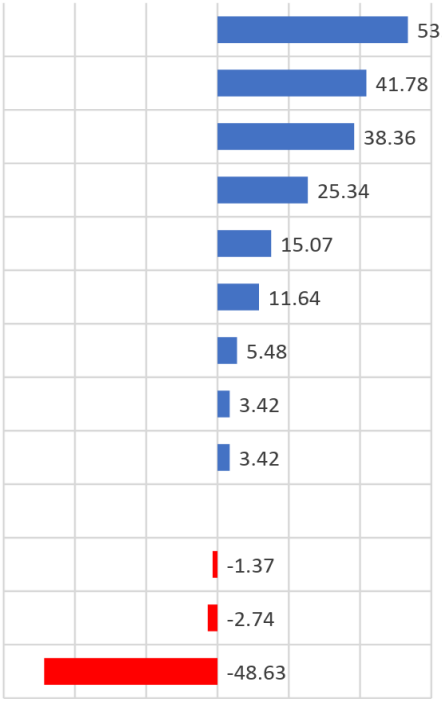
Table 5.3 Sociodemographic characteristics and SKAPS subscale

Knowledge	Standardized Coefficients			
	Beta	t	Sig.	M (95% CI)
Work place	.098	.830	.409	.66 (-.449 – 1.089)
Age	.058	.493	.623	44.6 (-.23 - .039)
Sex	-.005	-.043	.966	.85 (-1.047 – 1.003)
Marital status	-.143	-1.215	.228	.74 (-1.331 – .323)
Social status	-.016	-.135	.893	1.93 (-1.296 – 1.131)
Family members with mental illness	.015	.123	.902	.04 (-1.732 – 1.960)
Years of experience	-.23	-.196	.845	12.82 (-.033 – .027)
Unit (department)	.187	1.605	.113	.22 (-.170 – 1.571)
Number of night shifts	-.296	-1.547	.134	8.44 (-.310 – .440)

Perception	Standardized Coefficients			
	Beta	t	Sig.	M (95% CI)
Work place	-.337	-3.011	.004	.66 (-7.661 – -1.557)
Age	.033	.279	.781	44.6 (-.112 – .149)
Sex	.120	1.017	.312	.85 (-2.091 – 6.445)
Marital status	.034	.289	.773	.74 (-2.995 – 4.011)
Social status	-.138	-1.173	.245	1.93 (-8.011 – 2.077)
Family members with mental illness	-.101	-.859	.393	.04 (-11.026 – 4.388)
Years of experience	-.011	-.091	.928	12.82 (-.130 – .119)
Unit (department)	-.034	-.283	.778	.22 (-4.243 – 3.188)
Number of night shifts	.075	.375	.711	8.44 (-.603 – .871)

The *Perception* subscale revealed the following results. The largest objection (48.7%) was to the statement that there was no need to use medicines. This circumstance is connected with professional activity of nurses in our country which is focused on the use of psychopharmacotherapy. Nurses, especially those who are working in hospitals, see their role in providing drug treatment (Figure 5.3).

Figure 5.3. SKAPS- Perception Subscale



- Individuals with mental illnesses are victims of their disease and should be treated with sympathy.
- People with schizophrenia have behavioral patterns that are abnormal.
- Genetics are the primary factor in the development of schizophrenia.
- Most people fear people with schizophrenia.
- If treated and medicated, people with schizophrenia can function fairly typically in society.
- People with schizophrenia are dangerous.
- A person with schizophrenia's social problems are their own fault because they isolate themselves from others.
- Most mental illnesses are caused by substance abuse.
- In general, people with schizophrenia should be put into institutions.
- Individuals with mental illness are simply weak-willed, unmotivated people.
- Most people with mental illnesses are poor.
- People with schizophrenia should have the same educational, occupational, and social opportunities as ''normal'' individuals.
- Individuals with mental illnesses do not need medication; they just need to change their thought processes and behaviors.

On the other hand, the greatest consensus was that people with mental disorders are victims of their disease and need sympathy (53.4%). Part of this relationship is caused by a generally benevolent attitude towards the patients, which is often accompanied by some condescending epithets such as "poor", "unhappy", "unlucky".

The statement about the abnormal behavior of schizophrenic patients was also found among the respondents (41.8%). In fact, in inpatient practice they often observe acute psychotic conditions that are accompanied by prominent behavioral disorders.

Consensus with the affirmation of the role of genetics as the main factor in the development of schizophrenia is widespread in Azerbaijan, where people consider severe mental disorders as hereditary (38.7%).

There is also a prejudice regarding the social danger of people with mental disorders, which was confirmed by positive answers to the statement that most people are afraid of people with schizophrenia (25.3%).

The study on the *Social Distance Scale* was able to identify the relationship between social distance from the person with schizophrenia and the sex of the respondent (Table 5.4). Females tend to avoid people suffering from schizophrenia. Perhaps this is due to the fact that women are highly vulnerable to violence and thus are more sensitive to information about the "danger" of schizophrenic patients.

Also, there was a relationship between social distancing from a person with a conviction and a marital status of respondents. Those who are married have more cautious toward people who have been convicted in the past and try to avoid contact with these people. This is connected to the cultural background: the close family relationship with criminal generated negative perception of other family members, and the family itself is perceived as dysfunctional.

Table 5.4 Sociodemographic characteristics and Social Distance Scale

Schizophrenia	Standardized Coefficients	t	Sig.	M (95% CI)
	Beta			
Work place	.039	.328	.744	.66 (-.809 – 1.128)
Age	-.084	-.712	.479	44.6 (-.053 – .025)
Sex	.328	2.930	.005	.85 (.570 – 2.999)
Marital status	.210	1.809	.075	.74 (-.095 – 1.955)
Social status	-.160	-1.370	.175	1.93 (-2.536 – .471)
Family members with mental illness	-.116	-.986	.327	.04 (-3.440 – 1.1163)
Years of experience	-.152	-1.296	.199	12.82 (-.061 – .013)
Unit (department)	-.065	-.546	.587	.22 (-1.413 – .806)
Number of night shifts	-.300	-.149	.883	8.44 (-.242 – .209)

Depression	Standardized Coefficients	t	Sig.	M (95% CI)
	Beta			
Work place	.009	.078	.938	.66 (-.965 – 1.044)
Age	-.120	-1.022	.310	44.6 (-.061 – 0.020)

Sex	.097	.825	.412	.85 (-.778 – 1.874)
Marital status	.184	1.574	.120	.74 (-.225 – 1.911)
Social status	-.173	-1.478	.144	1.93 (-2.707 – .402)
Family members with mental illness	-.185	-1.585	.117	.04 (- 4.236 – .483)
Years of experience	-.152	-1.300	.198	12.82 (-.063 – .013)
Unit (department)	-.073	-.618	.538	.22 (-1.505 – .793)
Number of night shifts	-.328	-1.739	.094	8.44 (-.383 – .320)

Alcoholism or drug addiction	**Standardized Coefficients**			
	Beta	**t**	**Sig.**	**M (95% CI)**
Work place	-.080	-.675	.502	.66 (-1.578 – .779)
Age	-.043	-.360	.720	44.6 (-.056 – .039)
Sex	.085	.715	.477	.85 (-1.003 – 2.123)
Marital status	.085	.723	.472	.74 (-.812 – 1.736)
Social status	-.224	-1.937	.057	1.93 (-3.570 -.052)
Family members with mental illness	-.028	-.239	.812	.04 (-3.164 – 2.487)
Years of experience	-.135	-1.151	.253	12.82 (-.071 – .019)
Unit (department)	-.175	-1.496	.139	.22 (-2.338 – .333)
Number of night shifts	.101	.507	.617	8.44 (-.156 – .259)

Previous conviction	**Standardized Coefficients**			
	Beta	**t**	**Sig.**	**M (95% CI)**
Work place	-.105	-.889	.377	.66 (-1.444 – .554)
Age	-.110	-.931	.355	44.6 (-.590 – .021)
Sex	.120	1.017	.313	.85 (-.648 – 1.997)
Marital status	.256	2.233	.029	.74 (.126 – 2.225)
Social status	-.087	-.736	.464	1.93 (-2.152 - .991)
Family members with mental illness	-.071	-.603	.549	.04 (-3.118 – 1.670)
Years of experience	-.57	-.477	.635	12.82 (-.480 – .029)
Unit (department)	-.155	-1.324	.190	.22 (-1893 – .382)
Number of night shifts	.015	.73	.943	8.44 (-.228 – .245)

The correlation analysis of SDS data shows that the largest correlation was found between social distancing in schizophrenia and depression ($r = 0.744$, $p < 0.01$), while substance abuse and previous conviction showed a moderate correlation with other factors. (Table 5.5). Obviously, this is connected with overgeneralization of mental disorders without taking into

account their clinical differences from other states. At the same time, alcohol and drug abuse is perceived not as a mental disorder, but as a bad habit - the result of "weak will" and "poor influence of others."

Table 5.5 Social Distance Scale Correlation

	Schizophrenia	Depression	Substance abuse	Previous conviction
Schizophrenia	**1**			
Depression	**0,744****	**1**		
Substance abuse	**0,382****	**0,274***	**1**	
Previous conviction	**0,403****	**0,439****	**0,418****	**1**

** - Correlation is significant at the 0.01 level (2-tailed).

* - Correlation is significant at the 0.05 level (2-tailed).

Analysis of the correlation between the subscale CAMI and SKAPS revealed some interesting patterns. *Community Mental Health Ideology* has a moderate degree of correlation with *Social Restrictiveness* ($r = 0.314$, $p < 0.001$). It can be assumed that these two subscales are interconnected by the fact that they are based on knowledge of patients' rights and legal aspects of mental health services. Accordingly, the knowledge of *Community Mental Health Ideology* improves the attitude towards people with mental disorders and reduces their social restriction (Table 5.6).

Table 5.6 CAMI and SKAPS subscales correlation

	Authoritarianism	Benevolence	Social restrictiveness	CMHI	Knowledge	Perception
Benevolence	0,079	1				
Social restrictiveness	0,174	0,113	1			
CMHI	0,077	0,024	0,314**	1		
Knowledge	- 0,158	0,242*	0,198	0,063	1	
Perception	- 0,276*	- 0,068	- 0,208	- 0,280*	- 0,361**	1
Social distance	0,064	- 0,226	0,148	0,236*	- 0,077	- 0,044

** - Correlation is significant at the 0.01 level (2-tailed).

* - Correlation is significant at the 0.05 level (2-tailed).

The analysis revealed a weak negative correlation between the subscales *Perception* and *Authoritarianism, Community Mental Health Ideology, Knowledge*. This relationship is logical, given that the respondents' better awareness in nature of mental disorders, mental health policy

and the civil rights of service are contrary to the negative perception of people with mental disorders.

5.2. Changes in Attitudes, Knowledge and Social Distance.

Further analysis of various CAMI subscales revealed statistically significant differences between the three periods of assessment (Table 5.7, Table 5.10). It is important to note that the difference in *Authoritarianism* and *Social Restrictiveness* was related to pre-training and post-training scores while the post-training and 6-month follow-up assessment scores were approximately the same. It may be concluded that the attitudes obtained due to training remain stable for six-month period.

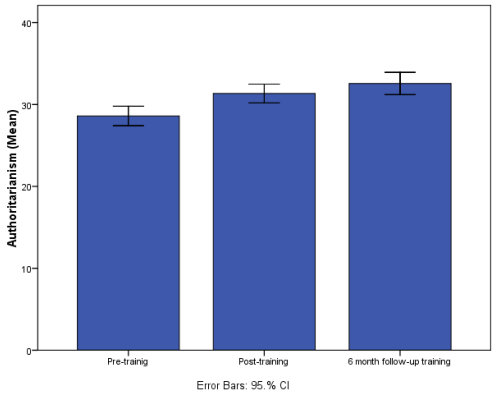
Table 5.7 CAMI Friedman Test

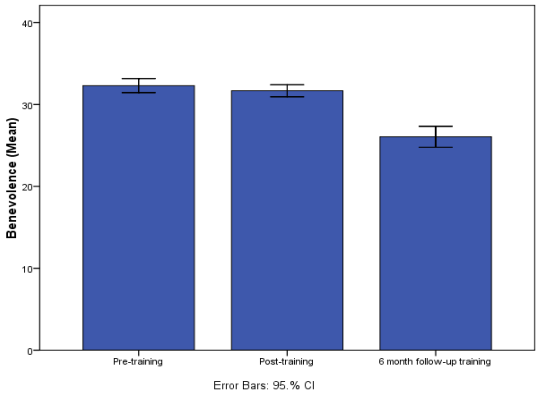
Variable	Pre-training	Post-training	6 month follow-up		
	M (SD)	M (SD)	M (SD)	X^2	P
Authoritarianism	28,60 (4,329)	31,34 (4,174)	32,57 (4,940)	20,912	0,000
Benevolence	32,30 (3,117)	31,68 (2,673)	26,06 (4,561)	49,02	0,000
Social restrictiveness	33,87 (4,372)	36,34 (4,702)	30,19 (5,240)	28,41	0,000
CMHI	34,6 (5,249)	36,15 (5,524)	31,07 (5,402)	20,56	0,000

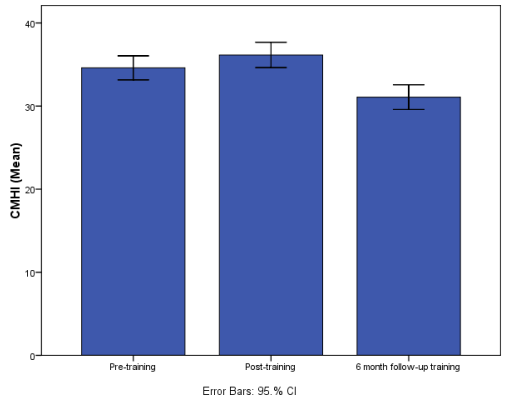
X^2 – Friedman Test

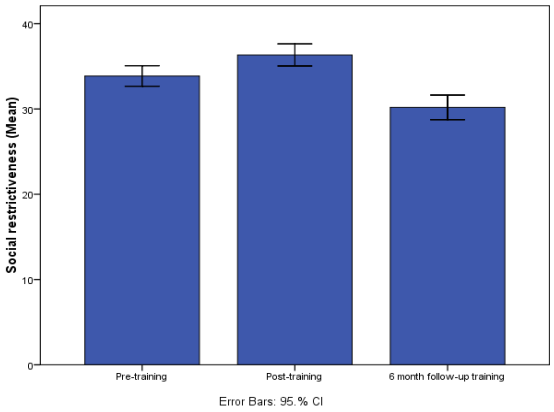
As for the *Community Mental Health Ideology* and *Benevolence*, the positive changes occurred within 6 months after the training. Perhaps this was due to the fact that the respondents took more time to accept and agree with the new knowledge obtained. (Figure 5.4)

Figure 5.4. CAMI results









The study did not reveal any changes in the level of *Knowledge*. This is due to the fact that the training focused on stigma and patients' rights protection rather than on information related to particular mental disorders. In addition, nurses often position themselves as "executors of doctor`s instructions" and do not consider it is necessary to understand the nature of symptoms in their patients. (Table 5.8, Table 5.10)

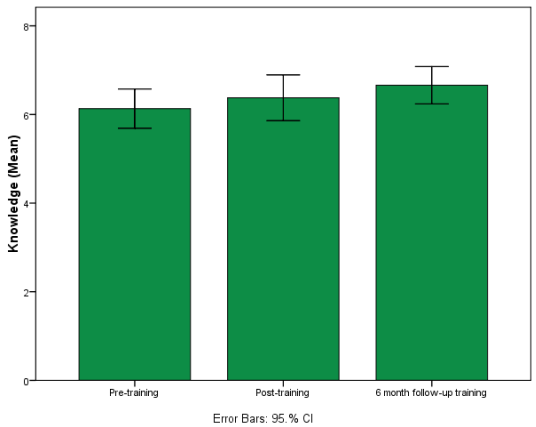
Table 5.8. SKAPS Friedman Test

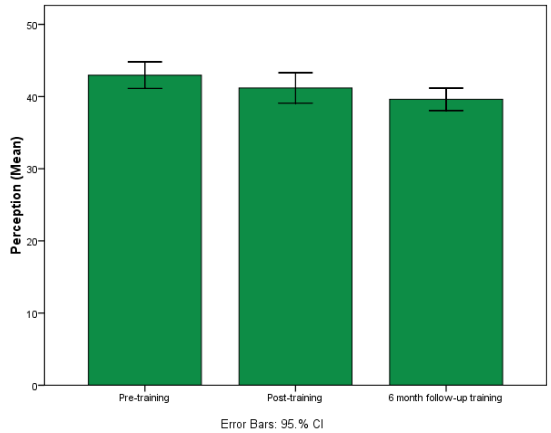
Variable	Pre-training	Post-training	6 month follow-up		
	M (SD)	M (SD)	M (SD)	X^2	P
Knowledge	6,13 (1,606)	6,38 (1,873)	6,6 (1,531)	0,749	0,688
Perception	42,96 (6,615)	41,19 (7,567)	39,61 (5,595)	10,32	0,006

X^2 – Friedman Test

The *Perception* indicators showed positive dynamics in comparison of pre-training and post-training assessment, and the result lasted for 6 months, which indicates the effectiveness and sustainability of the training program. (Figure 5.5.)

Figure 5.5. SKAPS results





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how important and highly prevalent this disorder is. In addition, according to respondents' statements, depression was perceived by them as "a state they often encounter themselves in everyday life", "a state that requires support from relatives …which is not associated with a social threat to others except the person may harm himself" and, unlike the other proposed states, "a person has no reason to hesitate or hide depression." (Table 5.9, Table 5.10)

Table 5.9. Social Distance Scale Friedman Test

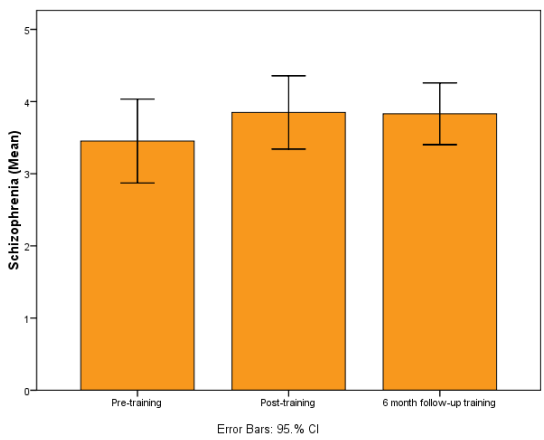
Variable	Pre-training	Post-training	6 month follow-up		
	M (SD)	M (SD)	M (SD)	X^2	P
Schizophrenia	3,45 (2,108)	3,85 (1,844)	3,83 (1,553)	4,83	0,089
Depression	3,54 (2,090)	4,02 (1,699)	3,83 (1,575)	6,143	0,046
Substance abuse	1,80 (2,580)	2,37 (2,824)	1,68 (1,911)	1,06	0,588
Previous conviction	3,11 (2,136)	3,09 (2,355)	3,55 (1,897)	1,226	0,542

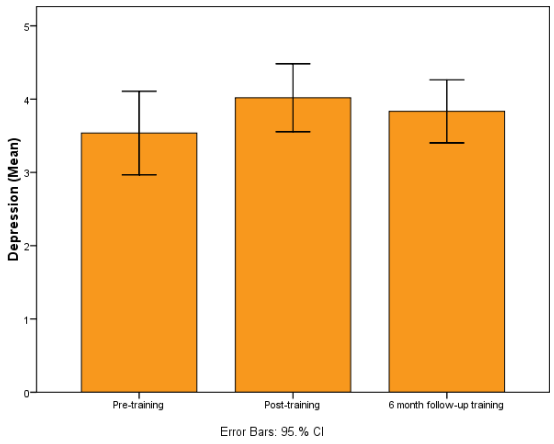
X^2 – Friedman Test

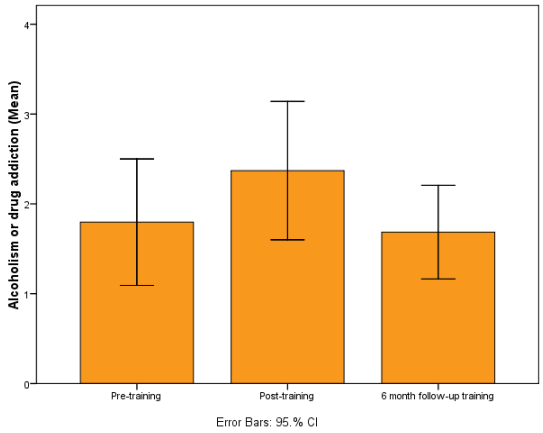
In relation to participants, there was a strong negative attitude towards *schizophrenia*, which was accompanied by statements that people with this disorder "lost control of themselves", "they are dangerous and you can expect anything from them," " less people know about their disease it is more better for them". Probably this persistent prejudice is caused by the fact that a single training is not enough to reduce significantly social distancing.

Concerning the *substance abuse* and *previous conviction*, it should be noted that the training program did not have information on reducing stigma toward them. It was not expected that the change in attitude towards these factors would occur (Figure 5.6)

Figure 5.6 Social Distance Scale results







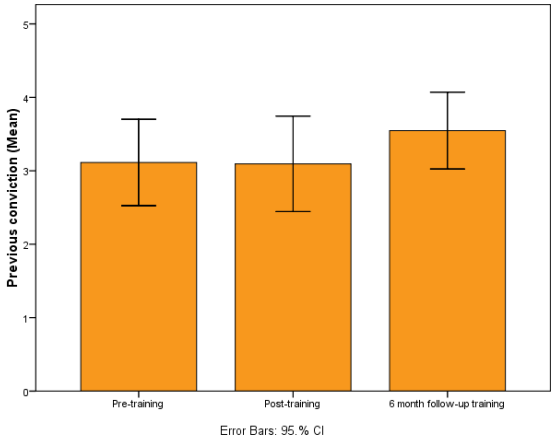


Table 5.10 Wilcoxon Test

	Pre-raining / 6-month follow-up		Pre-training / Post-training		Post-training / 6-month follow-up	
	Z	Asymp. Sig.	Z	Asymp. Sig.	Z	Asymp. Sig.
Authoritarianism	-3.783	0.000	-4.410	0.000	-2.036	0.042
Benevolence	-5.354	0.000	-0.756	0.449	-5.434	0.000
Social restrictiveness	-3.251	0.001	-3.594	0.000	-4.744	0.000
CMHI	-2.894	0.004	-1.738	0.082	-3.982	0.000
Knowledge	-1.457	0.145	-2.409	0.160	-0.842	0.400
Perception	-3.201	0.001	-3.537	0.000	-0.745	0.457
Schizophrenia	-1.238	0.216	-1.357	0.175	-0.168	0.867
Depression	-0.751	0.452	-2.740	0.006	-0.701	0.483
Substance abuse	-0.327	0.744	-2.440	0.150	-1.276	0.202
Previous conviction	-1.138	0.255	-0.432	0.665	-1.179	0.239

Chapter 6. DISCUSSION

6.1. Thesis findings in context

This is the first study in Azerbaijan aimed to determine the level of stigma among nurses working in psychiatric hospitals and relationship between stigma and the socio-demographic data of the study participants. There are numerous studies focused on stigma in health care, but most of them were carried out in the developed countries (Gearing et al., 2015, Gray, 2002; Jorm, Korten, Jacomb, Christensen, & Henderson, 1999; Kingdon, Sharma, & Hart, 2004; C. Lauber, Nordt, Braunschweig, & Rössler, 2006; Liggins & Hatcher, 2005; Magliano et al., 2004; Schulze, 2007; Steinert, Lepping, Baranyai, Hoffmann, & Leherr, 2005; Van Dorn, Swanson, Elbogen, & Swartz, 2005).

We adapted a number of scales, including CAMI, which were used in the study. The latter was originally developed to assess the level of *Authoritarianism, Benevolence, Social Restriction and Community Mental Health Ideology* among the general public (Taylor & Dear, 1981), but later it was used to assess stigma among mental health professionals (Chambers et al. , 2010; Kingdon et al., 2004; Lauber, Anthony, Ajdacic-Gross, & Rössler, 2004; Sevigny & Marleau, 1999)

This study did not identify a significant relationship between the *Authoritarianism* subscale and the socio-demographic data of the participants. A similar result was observed in several other researches (Bedaso, Yeneabat, Yohannis, Bedasso, & Feyera, 2016), which also failed to define the relationship between gender, age, education and marital status of respondents and *Authoritarianism.* However, in one study conducted in Spain, the researchers were able to describe the correlation between gender and *Authoritarianism* (Aznar-Lou, Serrano-Blanco, Fernández, Luciano, & Rubio-Valera, 2016). It can be assumed that this correlation was found due to a large sample of participants (n = 1872).

Notably, we found a negative correlation between the *Benevolence* subscale and the marital status of the respondents, which suggests that marriage might negatively affect benevolence towards people with mental disorders. A similar conclusion was reached by researchers studying stigma among the general population in Singapore (Yuan et al., 2016). The researchers identified a negative correlation between single marital status and stigma.

According to these results, people who are not married have less prejudice against people with mental disorders. Unfortunately, the authors do not give an explanation to this phenomenon;

it may be related to the fact that single nurses have more social communication and more access to information resulting in better attitudes towards patients.

Subscale *Social Restrictiveness* revealed an association with three socio-demographic factors: the social status of the respondent, work experience in psychiatry and the number of night shifts. The first two variables were associated with lower *Social Restrictiveness* but the number of night shifts was related to higher scores on this subscale.

There are many scientific papers confirming that higher economic status promotes more positive attitude and less paternalism towards people with mental disorders (Aznar-Lou et al., 2016; Bedaso et al., 2016). However, research in India showed that people with high income showed the highest level of stigma (Venkatesh, Andrews, Mayya, Singh, & Parsekar, 2015). The authors explained this fact in cultural context. In modern Indian society discrimination on the basis of caste is still existent. As a result, rich people avoid contacts with poor ones because this communication can affect their reputations and this rule extends to people with mental disorders because mental illness is attributable to poverty.

Researches on stigma conducted in general population revealed that personal experience of dealing with a person suffering from mental disorder improved the attitude towards this person, and effective modern programs on fighting stigma provide opportunity to listen mental health services users (Stuart, 2016, Vila-Badia et al., 2016). In our study conducted among psychiatric nurses, it was more practical to ask about the influence of work experience in this respect. As it was expected a positive relationship between work experience and *Social Restrictiveness* was observed in the study. Thus, it was found that longer work in a psychiatric hospital reduces social restrictiveness. Similar data were obtained in the study conducted among nurses in Ireland, which showed that health workers with less experience in mental health had more negative attitude and vice versa (Linden & Kavanagh, 2012).

The negative relationship between *Social Restrictiveness* and the number of night shifts can be explained by two reasons. The first reason is the desire to comply with strict regime in the department, for which they bear direct responsibility, thereby limiting the activity of patients at bedtime. The second reason is more subjective, which accounts to the fact that night shifts seem to be a significant factor of burnout, which may result in excessive strict and negative attitude towards patients. Burnout is one of the main indicators of well-being in health professionals. This is especially important when it is referred to people whose work is connected with provision of

services requiring emotional contact with users. Emotional and interpersonal work-related stress can cause burnout manifesting in three forms—cynicism or depersonalization, emotional exhaustion and perceived inefficiencies (Maslach, Schaufeli, & Leiter, 2001). Some studies have shown that burnout increased by frequent night shifts may result in developing negative attitude towards professional responsibilities, poor job performance and conflicts with service users. Such conflicts may lead to increase the use of social restrictive measures (Dunifon, Kalil, Crosby, & Su, 2013; Madide, 2003).

This study did not found out a relation between socio-demographic data and *Community Mental Health Ideology*. Another study in South Korea was conducted to identify changes in attitude towards people with mental disorders over ten years from 2000 to 2010 after the opening community mental health services in the city (Jung, Kang, & Lee, 2017). Based on the results of this study involving more than 1100 people, positive changes were identified for all four CAMI subscales. One of the factors promoting positive changes was having a family member with mental disorder. In this regard our study did not reveal relations between the presence of a person with mental disorder in a family and CAMI scores. But it is understandable due to the fact that only 3 out of 73 participants reported to have a patient in their families, which is not sufficient for statistical analysis.

A research conducted in five European countries (Portugal, Lithuania, Finland, Italy, Ireland) showed an association between *Community Mental Health Ideology* and socio-demographic data such as sex, position and resident country. According to the results of this study, females have a more positive attitude, while governmental officers as compared to freelancers reported a more negative attitude. In addition, the study revealed that the most positive attitude was found in nurses from Portugal, and the most negative attitude in nurses from Lithuania (Chambers et al., 2010). In the authors' opinion, this phenomenon was related to differences in education and culture.

The analysis of SKAPS scale provided similar results in our study, which showed an association between the location of the hospital and the perception of people with mental disorders. Nurses working in the capital city reported a more positive perception than their colleagues from the regions of the country. It is important to note that nurses living in the capital had better educational opportunities as well as some cultural distinctions.

The study did not reveal any relations between socio-demographic data and the participant's level of *Knowledge*. However, a similar study conducted in the United States through an online survey depicted a positive correlation between mental health experience and knowledge (Miele, 2014). Another study conducted on more than 1000 participants in France discovered that 95% of respondents knew the terms of mental disorders (e.g. autism, bipolar disorder, schizophrenia), but less than 70% were able to describe, their clinical characteristics. More than half of respondents reported people with schizophrenia were dangerous and expressed their desire to avoid them. But people who had a family member with a mental disorder showed a better knowledge and less social distancing towards patients (Durand-Zaleski, Scott, Rouillon, & Leboyer, 2012). The existing correlation between acquaintance with a person with mental disorder, *knowledge* about schizophrenia and social distancing was confirmed in other studies (Razali & Ismail, 2014). In fact, acquaintance with a person with a mental disorder decreases social distance which may be replaced by empathy and support, while caring this person increases knowledge in mental health issues including mental disorders.

The study conducted in the US among 330 students (Smith, Reddy, Foster, Asbury, & Brooks, 2011) pointed out a positive correlation between the level of *knowledge* about schizophrenia and tolerance to people living with this illness. In addition, tolerance positively correlated with the degree of relationship with a person with schizophrenia. It is interesting that in many cases people who had a family member with mental illness reported greater social distancing towards other patients than those who did not have psychiatric patients in their families. According to the authors, the presence of a family member with mental disorder increases knowledge and tolerance, while this relationship accompany a family burden of disease associated with emotional and social problems, which in its turn contribute to social distance towards other patients.

Although many similar studies have found an association between contacting people with mental disorders and *Social Distance Scale*, we could not identify this relation in our study.

At the same time, data analysis revealed a relation between the respondent's gender and distancing. According to the results, female sex increases distancing from people with schizophrenia. The researchers who conducted a study in South Korea came to the same conclusion (Jang et al., 2012). In addition, the authors noted that as the age of the respondent increased, his or her social distancing increased. It may be suggested that a higher level of education is associated with a lower prejudice attitude.

In a study from Switzerland, the authors compared social distancing between several groups of respondents in relation to a person with schizophrenia, a person with depression and a person without psychiatric symptoms but experiencing "difficult moment" in his/her life. The respondents were divided into five groups - psychiatrists, psychologists, psychiatric nurses, other doctors and general public. Higher degree of distancing was revealed for people with schizophrenia in all groups, regardless of socio-demographic variables of participants (Nordt, Rössler, & Lauber, 2006).

According to the authors of the study, the causes of a negative attitude were lack of awareness and prejudice. This explains why most of ongoing anti-stigma activities include educational programs (Griffiths, Carron-Arthur, Parsons, & Reid, 2014, Hanisch et al., 2016; Henderson, Evans-Lacko, & Thornicroft, 2013).

In this study, further analysis showed a statistically significant difference between the levels of *Authoritarianism, Social Restrictiveness, Community Mental Health Ideology, Benevolence* and *Perception,* before and after the training. This fact confirms our hypothesis that training against stigma is an effective tool to improve attitude towards people with mental disorders. However, the training did not significantly affect the level of *Knowledge* and *Social Distance* in this respect.

Many studies investigating the effectiveness of educational programs had similar results. For example, a UK study held among 1452 medical students included pre-training, post-training and 6-month follow-up assessment of participants (Friedrich et al., 2013). The Training Education Not Discrimination (END) was an integral part of the Time to Change program intended to reduce mental health stigma among professionals and professional trainees. The Mental Health Knowledge Schedule (MAKS) and Community Attitudes towards the Mentally Ill (CAMI) scales were used to assess knowledge and attitudes in training participants. Assessment of respondents just after the training demonstrated a significant increase in knowledge, improving attitude and better behavior as compared with a control group. But after 6 months of observation, almost all of the indicators decreased relatively to the results achieved before. In our study, a six-month follow-up assessment showed sustainable results, with the exception of social distancing towards people with depression. The different results between our study and British study may be explained by the fact that, unlike medical students, psychiatric nurses continued to contact patients and this

ensured maintenance of knowledge, attitudes and skills obtained through the training. Also, it is an argument in favour of the importance to contact patients directly to reduce stigma.

The impact of respondents' direct contact with patients was observed in another study, which included an analysis of pre- and post-training impact on reducing stigma among mental health specialists and general public (Cerully et al., 2016). The program used two training courses - Disability Rights California and Mental Health America of California. The researchers came to the conclusion that including communication with mentally ill persons (direct or through video) in the training program contributes to its effectiveness.

In addition, both training programs were more effective for trainees representing lay persons than for mental health services providers. This may be due to the fact that mental health services providers were initially less stigmatizing.

With this regard invitation of mental health professionals as trainers for anti-stigma training seems to be very effective. The training was provided by psychiatrists for 89 employers demonstrated high effectiveness in increasing knowledge, improving attitudes and reducing social distances for people with mental disorders (Jouet, Moineville, Favriel, Leriche, & Greacen, 2014). A study conducted among the Masters of Social Work (MSW) students using the "In Our Own Voice" program implemented by mental health professionals showed the same results. It should be mentioned that in this study, trainees had real contacts with people with mental disorders who told their stories and problems they had faced in their lives (Pittman, Noh, & Coleman, 2010).

The efficiency of online video program-based anti-stigma intervention for primary care nurses was confirmed in several studies held in Malaysia (Ng, Rashid, & O'Brien, 2017) and in South Korea (Seo & Kim, 2010). As for our study, it can be assumed that work in a psychiatric hospital associated with constant interaction with patients would promote better results of training for psychiatric nurses. In other words, the new knowledge may be immediately and successfully implemented into practice.

The study conducted in China focused on comparing two models of training based on materials from the WHO mhGAP Intervention Guide and the Chinese Medical Association's guidelines. (Li et al., 2015). The difference between the two programs was the ratio of materials related to Community Mental Health and Clinical Psychiatry. The program with a greater emphasis on Community Mental Health demonstrated better results than the Clinical program. This study confirmed the importance of community-based approach for mental health professionals training,

which is more effective in countering stigma and discrimination towards people with mental illness. The authors concluded that reducing stigma was definitely associated with increasing knowledge in specialists. At the same time our study could hardly support this conclusion, because absence of positive changes in the level of participants' knowledge did not affect improvement of their attitude towards people with mental disorders.

The efficiency of trainings focusing on countering stigma has been demonstrated in many other studies where target audience of training was mental health professionals. In one of these studies evaluating the effectiveness of the new "anti-stigma competence" pilot program, it was reported that mental health professionals are both stigmatized by others and stigmatizing patients (Zaske, Freimuller, Wolwer, & Gaebel, 2014). Along with positive results in reducing social distancing among program participants, the study revealed that the new skills not only decrease the stigmatizing attitude towards people with mental disorders but increased their capacity to recognize stigmatic situations and act immediately against them. The main barrier indicated by the training participants was self-separation from people with mental disorders through using the concepts "We" and "They" that prevented their awareness of stigma. It is likely that the efficiency of the program was related to the parallels between the state when the training participant is an object of discrimination and the state when he or she is a discriminator. In our study, a similar methodology was used to increase "emotional involvement" with trainees that resulted in better understanding of stigma.

Analysis of 80 different short- and long-term anti-stigma interventions revealed a number of interesting facts and made possible the development of recomendations (Thornicroft et al., 2016). For example, the target group including medical students who were presented psychiatric patients developed short-term improvement of attitude towards the patients, while their knowledge remained at the same level. At the same time most of the interventions were implemented in developed countries while the number of studies in low-income and middle-income countries was insufficient. In addition, long-term follow-up of training participants is required to assess sustainability of training results as well as to identify additional interventions supporting their progress.

6.2. Limitations of the study

One of the limitations of this study was the sample size, as it just included 73 psychiatric nurses. Therefore, it is difficult to generalize the results obtained for general population of nurses working in the country. Another limitation was related to the fact that only nurses working in psychiatric hospitals participated in the study. However, it is important to note that 73 nurses constitute 12% of the total number of psychiatric nurses in the country while 86% of psychiatric nurses in our country have been employed in psychiatric hospitals. Thus, our sample is representative because it takes into account the basic characteristics of psychiatric nurses.

The design of the study was cross-sectional, which does not allow considering casual relations. Also, the study did not have a control group, which would be desirable for determining the effect size of the training. As for randomization, it should be mentioned that cluster randomization was provided for hospitals selection. At the same time randomization of nurses working in the hospitals was not provided. It is important to note that almost all nurses working in the regional hospitals took part in the study.

All the instruments (CAMI, SKAPS, SDS) were used for the first time in Azerbaijan. Although back-translation of the instruments reduced disparity between the original and translated versions to a minimum, a formal validation of Azerbaijani versions was not done. However, the above mentioned studies conducted in different countries confirmed good psychometric properties, cross-cultural validity and reliability of the instruments.

Due to lack of randomization and relatively small sample size, normal distribution of the instruments' scores was not expected. With this regard, non-parametric tests were used in this study.

6.3. Conclusions and recommendations

The results of the study made it possible to identify the extent of stigma in nurses working in psychiatric hospitals.

One of the study components was training focusing on reducing stigma. Training had significant impact on developing positive attitude in nursing staff. Despite the fact that the training did not increase clinical knowledge of the participants, it had effect on decreasing authoritarianism

and restrictiveness, as well as on increasing benevolence and community ideology towards people with mental disorders. Training also improved perception of patients in its participants.

The social distance regarding people suffering from schizophrenia, drug abuse or previously convicted has not changed. As for depression, the training decreased social distance towards depressive patients, but the follow-up assessment showed it was not stable over six months after training.

Comparative analysis revealed that the positive effect obtained through training was sustainable during six months. This fact makes possible to calculate the frequency of trainings and to allocate appropriate resources.

The information obtained from this study allows formulating better understanding of the level of stigma in in-patients. Since stigma is one of the main barriers in seeking help from people with mental disorders, stigma in mental health workers is becoming a major challenge for recovery and service provision. Reduction of negative attitude in nursing staff should improve all the services provided including general healthcare and rehabilitation.

Based on the obtained results, the following recommendations have been developed:

1) The training demonstrated its effectiveness in addressing stigma in psychiatric nurses, therefore this type of training should be provided for all mental health professionals working in the country;
2) The further anti-stigma trainings along with mental health professionals should include participation of mental health services users to increase cooperation between service providers and recipients;
3) Although the training has improved attitude towards people with mental disorders it had small impact on the nurses' clinical knowledge. Therefore, training modules should also include additional materials on mental disorders, as well as information about the rights of people with disabilities;
4) The effect of training seems to be sustainable during six months and it should be recommended to provide training on regular basis once a year.
5) It is necessary to include anti-stigma training into the National Mental Health Action Plan as well as into post-graduate and continuous medical education of mental health professionals;

6) All used instruments revealed good psychometric properties and may be recommended in monitoring and research related to stigma among mental health professionals as well as other specialists and general public;
7) Further research should be implemented to investigate the effects of stigma on burnout, quality of life, satisfaction with care and family burden.

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APPENDIX 1: Community Attitudes toward Mental Illness (CAMI) Azeri version

	Ad Soyad _____	Tarix: ____/____/20___				
N	**SUAL | CAVAB**	**Tamamilə razı deyiləm**	**Razı deyiləm**	**Nə razı deyiləm, nə də razıyam**	**Rrazıyam**	**Tamamilə razıyam**
1	Psixi xəstələrə məsuliyyətli işlər tapşırılmamalıdır.	TRD	RD	N	R	TR
2	Psixi xəstələr cəmiyyətdən təcrid edilməlidir.	TRD	RD	N	R	TR
3	Sağalmış psixi xəstə ilə ailə quran qadın səhv qərar verməkdədir.	TRD	RD	N	R	TR
4	Mən psixi xəstə ilə qonşu olmaq istəməzdim.	TRD	RD	N	R	TR
5	Keçmişdə psixi problem olan şəxs dövlət müəssisələrində işləyə bilməz.	TRD	RD	N	R	TR
6	Psixi xəstələrin hüquqlarını pozmaq olmaz.	TRD	RD	N	R	TR
7	Psixi xəstələr normal həyat vəzifələrini yerinə yetirmək üçün dəstəklənməlidir.	TRD	RD	N	R	TR
8	Heç kəs psixi xəstəni qonşuluqdan qova bilməz.	TRD	RD	N	R	TR
9	Psixi xəstələr çox insanın hesab etdiyindən daha az təhlükəlidirlər.	TRD	RD	N	R	TR
10	Psixiatriya xəstəxanasında müalicə almış bir çox qadın dayə (uşağa baxan) kimi tövsiyə edilə bilər.	TRD	RD	N	R	TR
11	Psixi pozuntuların əsas səbəblərindən biri özünənəzarət və iradənin zəif olmasıdır.	TRD	RD	N	R	TR
12	Psixi xəstələrə ən doğru nəzarət üsulu onların bağlı qapı arxasında saxlanmasıdır.	TRD	RD	N	R	TR
13	Psixi xəstələri normal şəxslərdən fərqləndirən bəzi əlamətlər vardır.	TRD	RD	N	R	TR
14	Şəxsdə psixi pozuntu əlamətləri başlayan kimi o xəstəxanaya yerləşdirilməlidir.	TRD	RD	N	R	TR
15	Psixi xəstələrin uşaq kimi nəzarət və intizama ehtiyacı var.	TRD	RD	N	R	TR
16	Psixi pozuntuların digər xəstəliklərən fərqi yoxdur.	TRD	RD	N	R	TR
17	Psixi xəstələrə səfil kimi baxmaq olmaz.	TRD	RD	N	R	TR

18	Psixi xəstələrdən cəmiyyətin qorunmasına daha az fikir vermək lazımdır.	TRD	RD	N	R	TR
19	Psixi xəstələri psixiatriya xəstəxanalarında müalicə etmək köhnə üsuldur.	TRD	RD	N	R	TR
20	Hər kəs psixi xəstəliyə tutula bilər.	TRD	RD	N	R	TR
21	Psixi xəstələr həmişə gülüş mənbəyi olmuşdur.	TRD	RD	N	R	TR
22	Psixi xəstələrinin müalicəsi və qulluğa dövlət tərəfindən daha çox pul ayrılmalıdır.	TRD	RD	N	R	TR
23	Cəmiyyətdəki Psixi xəstələrə qarşı daha tolerant mövqe tutmaq lazımdır.	TRD	RD	N	R	TR
24	Bizim psixiatriya xəstəxanaları psixi pozuntusu olan şəxslərə qayğı mərkəzindən çox həbsxanaya bənzəyir.	TRD	RD	N	R	TR
25	Psixi xəstələr mərhəmətə layiq deyillər.	TRD	RD	N	R	TR
26	Psixi xəstələr cəmiyyət üçün yükdürlər.	TRD	RD	N	R	TR
27	Psixi sağlamlıq xidmətlərinə sərmayə qoyulması büdcəyə zərər verir.	TRD	RD	N	R	TR
28	Psixi xəstələr üçün kifayət qədər sayda xidmətlər vardır.	TRD	RD	N	R	TR
29	Psixi xəstələrdən uzaq olmaq yaxşıdır.	TRD	RD	N	R	TR
30	Psixi xəstələrə ən yaxşı xidmətlər göstərilməsi bizim borcumuzdur.	TRD	RD	N	R	TR
31	Yerli sakinlər yaxınlıqdakı psixiatriya müəssisələrini qəbul etməlidir, çünki onlar cəmiyyət üçün çalışır.	TRD	RD	N	R	TR
32	Normal cəmiyyətdə psixi xəstələrə ən yaxşı müalicələr təklif olunur.	TRD	RD	N	R	TR
33	Psixiatriya xidmətləri mümkün qədər adi tibbi müəssisələrdə həyata keçirilməlidir.	TRD	RD	N	R	TR
34	Yaxınlıqda yerləşən psixi sağlamlıq xidmətləri yerli sakinlər üçün təhlükə yaratmır.	TRD	RD	N	R	TR
35	Yerli sakinlər onların yaşayış ərazisində psixiatriya xidmətləri alan psixi xəstələrdən qorxmamalıdırlar.	TRD	RD	N	R	TR

36	Psixiatriya müəssisələri yaşayış yerlərindən kənarda yerləşməlidir.	TRD	RD	N	R	TR
37	Yerli sakinlərin psixiatriya müəssisələrinin onlaırn yaşayış ərazisində yerləşməsinə etiraz üçün bir çox əsasları var.	TRD	RD	N	R	TR
38	Yaşayış ərazisində psixi pozuntusu olan şəxslərin də yaşaması yaxşı terapiya ola bilər, lakin yerli sakinlər üçün böyük təhlükə törədir.	TRD	RD	N	R	TR
39	Psixi xəstələrin qonşuluqda yaşaması başqa insanlarda qorxu yaradır.	TRD	RD	N	R	TR
40	Yaşayış sahəsində psixiatriya müəssisələrinin yerləşməsi həmin əraziləri gözdən salır.	TRD	RD	N	R	TR

APPENDIX 2: Schizophrenia Knowledge, Attitudes and Perceptions Scale (SKAPS) Azeri version

	SUAL / CAVAB		
N	**Aşağıdakı maddələri oxuyun və doğru və ya yanlış olduqlarını qeyd edin.**	**Doğru**	**Yanlış**
1	Şizofreniya xəstələri ümumiyyətlə aqressiv olurlar.		
2	Şizofreniyalı xəstələr şəxsiyyətin (ikiləşməsi) pozuntusundan əziyyət çəkirlər.		
3	Şizofreniyalı xəstələr əsasən ailə üzvlərilə ünsiyyət saxlayırlar.		
4	Katatonik sindrom rigidlik, düşüncənin itirilməsi və ətraf mühitə qarşı reaksiyaların azalması ilə təzahür edir.		
5	Şizofreniyalı xəstələr cəmiyyəti qorumaq məqsədilə xəstəxanaya yerləşdirilməlidir.		
6	Şizofreniyanın səbəbi narkotik maddə istifadəsi ola bilər.		
7	Psixoz reallıq və rasional düşünmək qabiliyyətinin tam itirilməsidir.		
8	Bütün şizofreniyalı xəstələrdə eşitmə və ya görmə hallüsinasiyaları olur.		
9	Müalicə və dərmanların köməyilə şizofreniya sağaldıla bilər.		
10	Adətən, şizofreniyalı xəstələrdə intellekt göstəricisi aşağı olur.		
11	Bipolyar pozuntu səbəbsiz şəkildə tez-tez dəyişən əhval-ruhiyyə ilə xarakterizə olunur.		
12	Şizofreniya koqnitiv (qavrama, diqqət, təfəkkür və s.) qabiliyyətləri dəyişdirir.		

	Aşağıdakı cavablardan razı olduqlarınızı işarələyin:	**Tamamilə razıyam**	**Razıyam**	**Nə razı deyiləm, nə də razıyam**	**Razı deyiləm**	**Tamamilə razı deyiləm:**
13	Şizofreniyalı xəstələr əsasən xəstəxanaya yerləşdirilməlidir.					
14	Əksər psixi pozuntuların səbəbi narkotik maddə istifadəsidir.					
15	Psixi xəstələr təşəbbüssüz, iradəsiz insanlardır.					
16	Müalicə alan şizofreniyalı xəstələr cəmiyyətdə sərbəst fəaliyyət göstərə bilər.					
17	Şizofreniyalı xəstələr təhlükəlidir.					
18	Şizofreniyalı xəstələr öz problemlərində özləri günahkardır, çünki digər şəxsləri kənarlaşdırır.					
19	İrsiyyət şizofreniyanın əsas səbəbidir.					

20	Bir çox insanlar şizofreniyalı xəstələrdən qorxurlar.					
21	Əksər psixi xəstələr yazıqdırlar.					
22	Psixi xəstələrin dərman müalicəsinə ehtiyacları yoxdur, onlar sadəcə öz davranış və düşüncələrini dəyişməlidirlər.					
23	Psixi xəstələr öz xəstəliklərinin əsiridirlər və onlara mərhəmət göstərmək lazımdır.					
24	Şizofreniyalı xəstələrin davranışı normal deyildir.					
25	Şizofreniyalı xəstələr normal insanlarla eyni təhsil, peşə fəaliyyəti və sosial imkanlara malik olmalıdırlar					

APPENDIX 3: Social Distance Scale (SDS) Azeri version

Boqardus social təcridolma şkalası

Göstərişlər:

1. Hər bənddə ilk hiss etdiyiniz reaksiyanı qeyd edin.
2. Hər xəstəliyinə ümumi şəkildə öz reaksiyalarınızı qeyd edin. Tanıdığınız hər hansı mənfi və ya müsbət şəxsə istinadən cavablar verməyin, bütün qrupu əhatə edən fikirlərinizi qeyd edin. (Hə- Məni narahat edir, Yox - Məni narahatetmir)

2. İstədiyiniz sayda bəndi işarələyin.

SUAL / CAVAB	**Şizofreniya xəstəsi**	**Depressiya xəstəsi**	**Narkotik və ya alkoqol istifadəçisi**	**Keçmişdə məhkumluğu olan**
	Hə/Yox	Hə/Yox	Hə/Yox	Hə/Yox
Yeni qohum (evlilik)				
Yaxın dost				
Qonşuluqda yaşayan şəxs				
İş yoldaşım				
Adi vətəndaş				